Kay Armstead Center for Communicative Disorders
Dept. of Communicative Disorders and Sciences · Connie L. Lurie College of Education
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ADULT SPEECH & LANGUAGE APPLICATION

Please complete the application and then mail, fax, e-mail or deliver to KACCD. Date Received:

Please attach any previous reports from therapists or doctors.

CLIENT INFORMATION:

NAME: _____ Date of Birth: _____ Age: _____
last first middle initial month/day/year

Gender: _____ Place of Birth: _____ Primary Language: _____
country, city, state
Other Languages: _____

Address: _____ Preferred Phone: _____
street
Other Phone: _____
_____ E-mail: _____
city state zip

Who referred you? _____ Date of Application: _____

What is the reason for the referral/evaluation? _____

Name of person completing application: _____ relation to client: _____

CLIENT QUESTIONNAIRE

What do you feel is the problem with your speech, language, voice, fluency, swallowing, thinking, and/or hearing skills?

What do you feel has caused the problem(s)?

When did you first notice the problem?

What are some situations that make the problem worse? (Example: during confrontations, at restaurants, etc.). Please be specific.

CLIENT QUESTIONNAIRE (continued)

How does this problem handicap you in everyday life?

Please provide any additional information that may have bearing on your communication problem.

MEDICAL HISTORY

Doctor name: _____ Phone: _____

Hospital/Facility: _____ Phone: _____

Please list and describe any injuries, traumas, surgeries or hospitalizations you have experienced.

Do you have any chronic illnesses (seizures, convulsions, fainting, asthma, allergies, etc.). Please list and describe.

Please list current medications and the reason for taking each.

Have you had a hearing evaluation? yes no Date: _____ Location: _____

Do you have normal hearing? yes no Describe the findings and recommendations of the evaluation.

Have other's suggested that you do not hear normal yes no Please explain.

Please indicate which devices you use: Glasses Hearing aids Walker Orthodontics
Other: _____

SERVICE HISTORY

Have you been evaluated by a speech and language pathologis yes no (Please provide a copy of the report)
Name of therapist: _____ Location: _____
What recommendations were given? Please explain below.

Have you received speech and language services? yes no (Please provide a recent report)
What recommendations and goals were given? Please explain below.

In the space below, please provide any additional information and/or concerns regarding your speech, language, communication or hearing.

Is there anything else you would like us to know?

SO THAT WE CAN BETTER SERVE YOU PLEASE BE SURE TO ATTACH ANY RECENT REPORST SUCH AS:

- Doctor summaries
- Speech reports
- Rehab reports

CONTACT PERMISSIONS

_____ I do NOT consent to having specific information (identification, in regards to therapy/assessment, time and date of appointment) relayed in voicemail, text or e-mail.
(initial)

_____ I give permission to leave messages with specific information (identification, in regards to therapy/assessment, time and date of appointment) in the following methods:
(initial)

Preferred Phone: _____ Other Phone: _____

Email: _____