CLEVELAND STATE UNIVERSITY ~ SPEECH & HEARING CLINIC

Speech/Language: Adult Case History

Background Information

Name: _____ DOB: _____ Age: _____

Address: _____

Circle preferred contact: [H] _____ [W] _____

[Cell]_____ [Pager] _____

[Email]_____

Marital status: _____ Name of spouse/significant other: _____

Person completing this form (if client, put "self"): _____

Referred by:_____

Communication Profile

Describe your speech and language concerns in detail: _____

_____

_____

Date of onset: _____

Has your speech/language communication improved or worsened? Please explain. _____

_____

_____

Do you have difficulty swallowing? _____ If yes, describe. _____

_____

Has your voice quality changed recently? _____ If yes, explain. _____

Has your hearing ever been evaluated? _____ If yes, explain when, by whom and the results. _____

_____

Check ☑ if you experience difficulty with any of the following and if so, describe below:

- ☐ understanding conversations in quiet environments
- ☐ hearing in noise or groups
- ☐ talking on the telephone
- ☐ listening to TV or the radio
- ☐ socializing with friends and family
- ☐ taking care of yourself independently
- ☐ enjoying your hobbies

_____

_____

Do you compensate for your communication difficulty? _____ If yes, how? _____

_____

_____

Medical History

Check ☑ if you have a history of any of the following and if so, describe below:

☐ Diabetes	☐ Heart disease	☐ Hypertension	☐ Stroke/TIA
☐ Seizures	☐ Head injury	☐ Memory problems	☐ Neurological disorder
☐ Headaches	☐ Respiratory problems	☐ Allergies	☐ Balance problems/falls
☐ Hearing difficulties	☐ Vision problems	☐ Depression	☐ Other_____

_____

_____

_____

List your recent surgeries and hospitalizations, including the date(s) and reason(s). _____

_____

_____

Primary Care Doctor: _____

Medical Specialists: _____

_____

List your current medications:

Name	Reason	Amount	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check ☑ if you ever had the following therapies and if so, explain below:

☐ Speech-language therapy ☐ Physical therapy ☐ Occupational therapy

_____

_____

_____

Occupational and Social Factors

Highest level of education completed: _____

Occupation (or former occupation): _____

Brief description of your job duties: _____

Can you maintain your house, pay the bills and drive independently? _____ If no, who helps you?

_____

What are your hobbies? _____

Additional Information

Do you have any other information that would be helpful for us to know? _____

_____

_____

_____

_____

SAN/DL: 7/02