# THE WALDRON COLLEGE OF HEALTH AND HUMAN SERVICES

**Radford University Speech-Language and Hearing Clinic Radford University**

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*General Information:*

## Adult Case History Form Speech and Language

Date form completed:

Name:

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: Occupation:

Date of birth:

Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Zip: Business phone:

Employer:

Person completing form: Occupation:

Relationship to adult: Business phone:

Employer:

Referred by: Phone:

Address:

Family physician: Phone:

Address: Single: Widowed: Divorced: Spouse’s Name:

Children (Include names, gender, and ages):

Who lives in the home?

What languages do you speak? If more than one, which one is your primary language?

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What was the highest grade, diploma, or degree earned?

Do you have a speech-language and/or cogntive problem?

Yes No

Describe your difficulties.

\_W\_h\_e\_n d\_id y\_o\_u\_f\_i\_rs\_t\_n\_o\_t\_ic\_e\_t\_h\_e\_p\_r\_o\_b\_l\_em ? .

Did it begin suddenly? gradually? .

What do you think may have caused the problem?

Has the problem chanced since it was first noticed? If yes, describe.

Have you seen any other speech-language pathologists? Who and when? What were their conclusions or suggestions?

Have you seen any other specialists (physicians, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist’s conclusions or suggestions.

Are there any other speech, language, learning, or hearing problems in your family? If yes, please describe.

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AUDITORY HISTORY:

Do you have a hearing problem? Yes No . If “yes”, continue: Which ear is affected? Right . Left . Both .

When did you first notice your hearing loss?

Did it begin suddenly? gradually?

Has your hearing loss gradually gotten worse? Yes No

Does your ability to hear change from day to day? Yes \_ No \_ What do you think caused your hearing loss?

Do you hear sounds (“tinnitus”) in your ears or head? Yes \_No \_

Do you ever experience dizziness, balance problems, or spinning sensation? Yes No

If “yes”, please describe fully

## Medical History:

Provide the approximate ages at which you had the following illnesses and/or conditions:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Illness/Condition** | **Age** | **Illness/Condition** | **Age** | **Illness/Condition** | **Age** |
| Adenoidectomy |  | Encephalitis |  | Noise Exposure |  |
| Allergies |  | Headaches (severe) |  | Otosclerosis |  |
| Asthma |  | Hearing Loss |  | Pneumonia |  |
| Chicken Pox |  | Heart Attack |  | Seizures |  |
| Cardiovascular  Disease |  | Mastoiditis |  | Stroke |  |
| Diabetes |  | Measles |  | Tinnitus |  |
| Dizziness |  | Mumps |  | Tonsillectomy |  |
| Draining ear |  | Meningitis |  | Vision changes |  |

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Please describe your present general health.

Describe other major health concerns. Have you been hospitalized within the past five years? Yes No If yes, describe

Check any of the following assistive devices that you use:

. wheelchair . walker . quadcane/hemiwalker . cane Do you have any eating or swallowing difficulties? If yes, describe.

List all medications you are taking:

Are you having any negative reactions to these medications? If yes, describe.

Please describe any allergies:

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Describe any major surgeries, operations, or hospitalizations (include dates).

Describe any major accidents:

Provide any additional information that might be helpful in the evaluation or remediation process.