THE WALDRON COLLEGE OF HEALTH AND HUMAN SERVICES
Radford University Speech-Language and Hearing Clinic
Radford University
P. O. Box 6961
Radford, VA 24142
(540) 831-7166
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Adult Case History Form
Speech and Language

General Information:

Date form completed:_____

Name:_____ Date of birth:_____

Address:_____ Phone:_____

City: _____ Zip: _____

Occupation: _____ Business phone:_____

Employer:_____

Person completing form:_____ Relationship to adult:_____

Occupation: _____ 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?

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

Do you have a speech-language problem? Yes_____ No_____

Describe your speech-language problem.

When did you first notice the problem?_____.
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.

_____
_____

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 suffered the following illnesses and conditions:

Illness/Condition	**Age**	**Illness/Condition**	**Age**	**Illness/Condition**	**Age**
Adenoidectomy		Encephalitis		Noise Exposure	
Allergies		German Measles		Otosclerosis	
Asthma		Headaches		Pneumonia	
Chicken Pox		Hearing Loss		Seizures	
Colds		High Fever		Sinusitis	
Convulsions		Influenza		Tinnitus	
Croup		Mastoiditis		Tonsillectomy	
Dizziness		Measles		Tonsillitis	

Draining Ear		Meningitis		Other:	
Ear Infections		Mumps		Other:	

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:

_____

_____

_____

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.