TEXAS WOMAN'S UNIVERSITY
Department of Communication Sciences & Disorders
P.O. Box 425737, Denton, TX 76204-5737
Phone: (940) 898-2285 | Fax: (940) 898-2276 | TTY: (940) 898-2019

Speech-Language Hearing Clinic

AUDIOLOGY ADULT CASE HISTORY Date ____________

Name: ____

Address: ____
Street Apt. #

____
City State Zip

Phone Number: ___________________________Email:_______________________________

Date of Birth:______________________ Age:______ Male ☐ Female ☐

Referred by: ____

Reason for testing: ____

____

Have you had a hearing test before? Yes ☐ No ☐

If yes, where and when? ____

What were the results? ____

Has there been an illness that has affected your ears or hearing? Yes ☐ No ☐

If yes, please describe: ____

Is there a history of ear infections? Yes ☐ No ☐

If yes, please describe: ____

History of ear surgery? Yes ☐ No ☐

If yes, please describe: ____

Do you have a feeling of pain or fullness in your ear(s)? Yes ☐ No ☐

If yes, please describe: ____

Have you had any dizziness? Yes ☐ No ☐

If yes, please describe: ____

Do you hear any noises in your ear(s)? Left ear ☐ Right ear ☐ Both ears ☐ No ☐

Please describe:____

Have you ever been exposed to loud noises occupationally or recreationally? Yes ☐ No ☐

If yes, please describe: ______________________________

Do you use hearing protection consistently when working around noise? Yes ☐ No ☐

Three of your most difficult listening situations are:

1. ______________________________
2. ______________________________
3. ______________________________

Does your hearing interfere with communication? Yes ☐ No ☐

If yes, please describe ______________________________

____

Has anyone in your family had a history of hearing loss? Yes ☐ No ☐

Please describe relationship and type of loss (if known):______________________________

____

Do you have any problems hearing? Yes ☐ No ☐

Which ear? Right ☐ Left ☐ Both ☐

When did you first notice it?______________________________

Has the hearing loss been: Sudden ☐ Gradual ☐ Fluctuating ☐

Have you ever used a hearing aid? Yes ☐ No ☐

If yes, please describe type and use:______________________________

______________________________ ______________________________

Signature Date

In case of emergency, please notify:

______________________________ ______________________________

Name and Relationship Contact number

Please complete the additional authorization forms that are attached. Once we have received the completed packet in our office, you will be contacted to schedule an evaluation.

For your convenience, you may mail this packet to the address on the first page or you may fax it to (940) 898-2276.

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Authorization for Evaluation/Treatment

I hereby authorize the following evaluations and/or treatments of ________________________________
(Please print clients' name)
in the Speech & Hearing Clinic at Texas Woman's University.

Please circle the choice(s) below

Speech/Language   Developmental/Feeding/Oral Motor   Audiological/Hearing

I hold the Speech & Hearing Clinic, Department of Communication Sciences, School of Occupational Therapy and Texas Woman's University harmless and waive any liability for injury, accident or illness to the client, caregivers, siblings, family members, or any other persons accompanying the client or family to the evaluation or therapy which may occur during or as the possible result of the course of evaluation/treatment.

I authorize that the evaluation and/or treatment procedures may be observed, videotaped, photographed, and discussed by students in disciplines related to the Speech & Hearing Clinic for academic, training, and advertising purposes. Furthermore, I authorize that the evaluation and/or treatment data may be used for research purposes as approved by appropriate University authorities.

It is my understanding that the examination findings and therapy reports will be treated as confidential materials and released only to such additional professional persons or agencies as I may authorize.

__________________   ____
Date   Please print name

____
Client or Parent/Guardian Signature

____
Address

____
City   State   Zip

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Disclosure Form

_________________________ _______________ __________
Patient Name (Please print) | Date of Birth | File#

Please read and initial in the space provided.

___________I understand that, by federal law, Texas Woman's University may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this disclosure form indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.

___________ I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

___________ I understand that copies of the Speech, Language, and Hearing Clinics HIPPA Privacy Practices are available to me in the clinic office.

___________ I understand that I may refuse to sign this disclosure form. I also understand that the institution or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this disclosure form.

___________ I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected be the federal medical privacy law and could be disclosed by the person or agency that receives it.

This disclosure expires automatically upon ____
(Specify date, event, or one year from date of signature)

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: ____

Please print name: _________________________________ Date: ___________________

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AUTHORIZATION FOR RECORDING AND USE OF EVALUATION/TREATMENT PROCEDURES

I hereby authorize that the evaluation/treatment procedures of___________________________
Clients' Name
may be recorded, videotaped, photographed, audio taped at the Department of Communication Sciences and Disorders at Texas Woman's University.

____
Initial

I authorize that the recorded evaluation/treatment procedure may be used for educational, research and advertising purpose both within and outside the University.

____
Initial

I authorize that the evaluation/treatment procedures may be observed and discussed, by student in disciplines related to the Department of Communication Sciences and Disorders for academics purposes.

____
Initial

Furthermore, I authorize that the evaluation/treatment data may be used for research purposes as approved by the appropriate University authorities.

____
Initial

I understand that the evaluation/treatment procedures will be treated confidential material and will be released only to additional professional persons or agencies as I may authorize.

____
Date

____
Client or Parent/Guardian Signature

____
Address

____
City State Zip

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AUTHORIZATION FOR CONFIDENTIALITY

I authorize that the evaluation and/or treatment procedures and information regarding the same may need to be e-mailed back and forth between Texas Woman's University and the parent/guardians and between the supervisors and students. I authorize that this procedure may be used to further the understanding between clinical personnel and parent/guardian. Should I chose not to authorize this communication, students and supervisors will communicate via an in-house discussion board accessible only to personnel of the clinic, but will not use e-mail to communicate with me.

__________initial

I realize that the evaluation and/or treatment procedures might be observed in the room where the T.V. monitors are located or in the Lab room by other parents/guardians. Because of the use of earphones, they should not be able to hear the sessions. I understand that privacy will be observed as much as possible.

__________initial

I understand that I may revoke my permission at any time by communicating in writing with the clinical coordinator.

____
Date

____
Parent/Guardian Signature

____
Client's Name