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-AUDIOLOGY
# CASE HISTORY
# FOR ADULTS

Date: _____

## I. REFERRAL

Who referred you to this clinic? _____

Professional title and/or relationship: _____

Address: _____
Street City State Zip

Phone Number: _____

Which of the following evaluation(s)/and/or therapy are you interested in?

Audiology Evaluation ☐ Speech/Language Evaluation ☐ Both Evaluations ☐

Speech Therapy ☐ Accent Reduction ☐

What are your concerns in the areas of hearing, speech and language? _____

_____

_____

_____

## II. IDENTIFICATION

Name_____ Age: _____

Date of Birth: _____ Male ☐ Female ☐

Address: _____
Street

_____
City State Zip Code

Home Phone:_____ Cell Phone: _____

Email Address: _____

Occupation: _____ Work Phone: _____

Family physician: _____ Phone: _____

Does anyone in the family have speech or hearing problems? Yes ☐ No ☐

If yes, indicate the relationship and explain the type of problem: _____

_____

Military Service? Yes ☐ No ☐ Branch of Service _____

Years of service_____

Have you received any rehabilitation services? Yes ☐ No ☐ If yes, please provide the dates and the provider's identification:

Facility or specialist:

Speech reading:_____

Auditory training: _____

Speech therapy:_____

Voice therapy:_____

Psychological therapy: _____

Counseling:_____

Vocational: _____

Other: _____

Additional comments: (evaluate your success in the above programs if any) Why was therapy terminated: _____

_____

**III. EDUCATIONAL-VOCATIONAL HISTORY**

What are some of your duties at your current job?_____

_____

Your best performance at work is in what area?_____

_____

What part of your job is particularly difficult or challenging?_____

_____

What is your preferred occupation? _____

If you are not employed, how long have you been unemployed? _____

Are you planning to return to some type of work? Yes ☐ No ☐

If so, will you need special training or help? Yes ☐ No ☐

If yes, please explain: _____

What was the last grade attended in school? _____

What kind of grades did you usually get in school? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Which subjects were the most difficult?_____

Which subjects were the easiest? _____

Have you ever been diagnosed with any of the following? Please check all that apply;

Speech/Language Problem ☐
Neurological damage ☐
Dyslexia ☐
Mental Retardation ☐
Attention difficulties ☐
Learning difficulties ☐
Emotional difficulties ☐
Hyperactivity ☐

What is the primary language spoken in your home?_____

What other languages are spoken in your home? _____

If English is your second language, how long have you spoken English? _____

Please provide any additional information which you feel will help us to understand your communication needs better: _____

_____

**IV. MEDICAL INFORMATION**

Family physician: _____

Address:_____ Phone: _____

Are you currently receiving Medicare? Yes ☐ No ☐

Check disease(s) you have had:

_____ Allergies _____ Asthma _____ Bronchitis _____ Chicken Pox

_____ Colds(frequent) _____ Ear Infections _____ Hay Fever _____ Headache(frequent)

_____ Heart Disease _____ Influenza _____ Measles _____ Kidney Disease

_____ Meningitis _____ Mumps _____ Pneumonia _____ Scarlet Fever

_____ Seizures _____ Tonsillitis

Other illnesses or physical disabilities not noted above: _____

Describe after effects of any illness, if any: _____

_____

Have you ever been hospitalized? Yes ☐ No ☐ If so, when and what for? _____

_____

Current medications (include aspirin and other non-prescription drugs/herbal remedies): _____

_____

_____

Current health status: Poor ☐ Fair ☐ Good ☐ Excellent ☐

Do you have difficulty with balance, dizziness, fear of heights or being moved? Yes ☐ No ☐

If yes, please describe: _____

Do you wear glasses? Yes ☐ No ☐

Health of other family members: Good ☐ Bad ☐ Please explain: _____

_____

Is there a family history of hearing loss? Yes ☐ No ☐

Is there a family history of learning disabilities? Yes ☐ No ☐

Is there a family history of speech or language difficulties? Yes ☐ No ☐

Is there other pertinent family history? Yes ☐ No ☐ Please explain: _____

_____

**V. EAR HEALTH**

Do you experience ear pain? Yes ☐ No ☐ If so, which ear? Left ☐ Right ☐ Both ☐

If yes, how often? _____

Do you have discharge? Yes ☐ No ☐ If so, which ear? Left ☐ Right ☐ Both ☐

If yes, how often? _____

Do you experience sensation of fullness or pressure in your ears? Yes ☐ No ☐

Do you experience episodes of dizziness or imbalance? Yes ☐ No ☐ If yes, how often?

_____

Do you experience unexplained episodes of nausea? Yes ☐ No ☐ If yes, how often?_____

Do you experience tinnitus (ringing in your ears)? Yes ☐ No ☐ If yes, describe the type:
buzzing☐ hissing☐ thumping☐ ringing☐ steam☐ other:_____ _____

If so, which ear(s)? Right ☐ Left ☐ Both ☐

Have you had ear surgery? Yes ☐ No ☐ Have you had nose surgery? Yes ☐ No ☐

Have you had throat surgery? Yes ☐ No ☐ Please explain any ear, nose or throat surgery you have had: _____

_____

What is your experience with noise exposure (prior or current)?_____

_____

Do you have a hearing loss? Yes ☐ No ☐ If yes, please continue. If no, please skip to section **VI.**

When did you first notice your hearing loss? _____

Was it sudden or gradual onset? Sudden ☐ Gradual ☐

Do you know what caused your hearing problem? Yes ☐ No ☐ If yes, please explain ___

_____

Which is your better ear? Right ☐ Left ☐ Both the same ☐

Does your hearing fluctuate? Yes ☐ No ☐

Check all the situations in which you have difficulty hearing:

In quiet ☐ In conversation ☐ In conferences ☐ In noise ☐ on the telephone ☐

Radio, TV, or movies ☐ Female voices ☐ Male voices ☐ Other, please specify: _____

_____

Have you had a previous hearing test? Yes ☐ No ☐ If yes, where and by whom? _____

_____

Have you ever worn a hearing aid? Yes ☐ No ☐ If yes, which ear? _____

Are you still wearing one? Yes ☐ No ☐ If no, please explain: _____

_____

## VI. ADDITIONAL INFORMATION

Please provide any additional information which you feel will help us to understand your communication needs better:

_____

_____

_____

_____

_____

_____

In the case of an emergency, please notify:

_____ _____

Name and Relationship Contact Number

_____ _____

Client Signature Date

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

If you have any questions, please contact the clinic at 940-898-2285. You may mail this packet to the address below, or you may fax it to 940-898-2276.

Mail to:
Texas Woman's University
Speech & Hearing Clinic – MCL 601
P.O. Box 425737
Denton, Texas 76204
Attn: D. Michele Stapleford

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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 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

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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