Brigham Young University
Speech-Language and Hearing Clinic

ADULT CASE HISTORY

Please fill out this form as completely as possible, especially the items marked with an asterisk. If you need more space, attach another page, or write on the back. Call 422-2870 if you have additional questions regarding these forms.

Date:____________________________

*Name:____ *Birthdate:______________________*Age:_________ Gender: F M

Phone:__(home)_____________________________(cell)_______________________________(work)______________________________

Best time to call:____Email:____

Address:____

City:____State:_____________________________ZIP:________________________________

Spouse or responsible party:____ Age: ____________________

*Reason for referral:____Referring person:_________________________________

Health History

Birth History

*Do you know of any difficulties during pregnancy, labor, or delivery?____

____

What was your mother's age:______________and health:_______________________________at your birth?

Did you have any of the following at birth: Jaundice? Y N Cyanosis? Y N Rh incompatibility factors? Y N

Medical History

*Please mark if and when you have had any of the following:

___ Seizures ___ High fevers ___ Measles ___ Mumps
___ Chicken pox ___ Whooping cough ___ Diphtheria ___ Bronchitis
___ Pneumonia ___ Tonsillitis ___ Meningitis ___ Encephalitis
___ Rheumatic fever ___ Tuberculosis ___ Sinusitis ___ Chronic colds
___ Enlarged glands ___ Thyroid ___ Asthma ___ Heart trouble
___ Chronic Laryngitis ___ Diabetes ___ Head injuries

For items marked above, give the relevant details (e.g., how frequent and/or how severe are these episodes?):_______________________

____

Recurrent earaches/ear infections?_________ Describe: ____

Are immunizations current?__________________________________Current general health? ______________________________________

Allergies? (Describe) ____

Any other serious or recurrent illnesses?_____________________________When?____

Any operations?____When?____

Any accidents?____When?____

Any medications?_(Past)_________________________________(Current)____

*Hearing difficulties?____________________ If so, Aided?____

Vision problems?________________________ If so, treatment?____

Dental problems:________________________Treatment:____

Other:____Left or right handed?____________________

Personal Medical Information

Personal Primary Physician:____________________ Date of last visit:____________

Address or Location:____________________

Ongoing Medical Care (Describe):____________________

Physician's Name:____________________ City:____________________

Current Medications: Dosage: Physician: Location:

____

____

Chronic Health Problems (Asthma, Congenital Defects, etc.):____________________

Handicaps (Describe, if any):____________________

Family

Names and ages of children:____________________

____

*Any speech or hearing problems in the family?__________ Explain:____________________

____

Speech and Language

Do you know of any concerns regarding early speech and language development? __________ Describe:____________

____

Other language(s) spoken in the home:____________________

Have you ever had difficulty understanding or expressing yourself? ______________ Describe:____________

____

*What are your communication needs in social settings?____________________

____

*What difficulty do you have meeting your communication needs?____________________

____

Educational History

Schools attended:____________________

Diplomas or degrees:____________________

Future educational plans:____________________

Were you or are you satisfied with your academic performance? __________ If not, why not?____________

*How did or does your communication difficulty affect your performance in school?____________

____

Vocational History

*How have communication difficulties affected the types of jobs you have held?____________

____

*Describe your current job setting and your communication needs:____________________

____

*How do communication problems affect your current job?____

____

*Does your communication difficulty affect your future job plans?____________ Explain: ___________________

____

General Information

Hobbies:____

Social and/or civic groups to which you belong:____

____

Other information you would like us to know:____

____

____

____

*** PLEASE MAIL THESE COMPLETED FORM, ALONG WITH ANY OTHER APPLICABLE CASE HISTORY FORMS (EX. VOICE, FLUENCY, ACCENT REDUCTION) TO:**

BRIGHAM YOUNG UNIVERSITY
ATTN: SPEECH-LANGUAGE CLINIC
136 TLRB
PROVO, UT 84602

PLEASE SEND RELEVANT REPORTS AND INFORMATION FROM OTHER AGENCIES IN A SEPARATE ENVELOPE.