**SPEECH AND HEARING CENTER** Phone: 251-445-9378
University of South Alabama FAX: 251-445-9377
Department of Speech Pathology and Audiology
5721 USA Drive North Room 1119, Mobile, Alabama 36688-0002

# ADULT CASE HISTORY FORM

## Speech-Language Pathology

Date______________

Patient's Name__________________________ Date of Birth____________ Male___ Female___
Address________________________________________________________________________
Street City State Zip

Telephones: Home________________ Cell________________ Work__________________
Email_______________________________________Occupation_____________________________
Highest Grade Completed_______ Marital Status______________ Spouse's Name_______________

Persons living in the Home:

| Name | Age | Sex | Grade Completed | Employer |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Primary Care Physician______________________________________________ Phone___________________
Referred by_______________________________________________________ Phone___________________
Address____________________________________________________________________________________
Street city state zip

Briefly describe the communication problem__________________________________________________
_______________________________________________________________________________________

Check any condition(s) that apply or describe why you were referred:

- Stuttering/Stammering
- Hoarse or weak voice
- Other voice problem
- Laryngectomy
- Communication problems from stroke
- Communication problem from head injury
- Dialect/pronunciation problems
- Swallowing problems
- Mental retardation
- Dementia/Cognitive problems
- Hearing loss
- Cochlear implant

Other ___________________________________________________________________________

1. What do you feel is the cause of your speech/language or hearing problem?
_______________________________________________________________________
2. Did you have any speech/language or hearing problems in childhood?_______ If yes, please describe__________________________________________________________________

3. Does anyone in your family have the same or other communication problem? ________ If yes, describe_______________________________________________________________________
4. What previous testing and/or treatment have you had for this problem?
   _______________________________________________________________________________
5. How often/under what circumstances are you required to talk?
   _______________________________________________________________________________
6. Do you wear hearing aids? _______ Dentures? ________ Eyeglasses? __________

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Employment experience (begin with present employment):

| Employer | Title/Job Description |
|---|---|
| ________________________________________ | ________________________________________ |
| ________________________________________ | ________________________________________ |
| ________________________________________ | ________________________________________ |

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Check any illness or conditions that apply to you:

| | | |
|---|---|---|
| High blood pressure | Drug abuse | Asthma |
| High cholesterol | Ear infections | Vision problems |
| Diabetes | Heart problems | Hearing problems |
| Smoking | Stroke | Learning problems |
| Alcohol use | Head injury | Mental health problems |

List any surgeries/accidents/injuries:

| Problem | Date |
|---|---|
| ________________________________________________________ | ____________________ |
| ________________________________________________________ | ____________________ |
| ________________________________________________________ | ____________________ |

List all medications taken regularly: _________________________________________________
_______________________________________________________________________________

Do you have any physical limitations, such as paralysis? _________________________________
_______________________________________________________________________________

Additional Comments: ________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

**PLEASE ASK YOUR PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL TO FAX ANY PERTINENT MEDICAL RECORDS TO THIS CLINIC PRIOR TO YOUR APPOINTMENT. FAX#:251-445-9377 ATTN: CLINIC SECRETARY**

__________________________________________
Signature of person completing form