CLARION UNIVERSITY OF PA
SPEECH AND HEARING CLINIC
CASE HISTORY - ADULT

I. Identification

Client's Name____________________________Sex________Admittance Date____________________

Date of Birth________________________Present Age___________Marital Status____________________

Address____Phone - Home__________________________

____Phone -Work__________________________

Referred
By____Physician____________________________

Insurance Company __________________________________Group # ____________________________

Agreement #__________________________

Closest Living Relative's Name___________________________Relationship__________________________

Address____Phone -Home__________________________

____Phone - Work__________________________

Please list all agencies that presently provide care/services for client:

____

____

____

II. Medical History

A. Description of present health of client____

____

B. Does client have any type of medical diagnosis? Yes_____ No _____

If yes, please list diagnosis:____

And date of onset: ____

C. Medications - Is client using any medications? Yes_____ No _____ If yes, list:

Medication Name______________________Date__________________Dosage__________________

Medication Name______________________Date__________________Dosage__________________

Medication Name______________________Date__________________Dosage__________________

Medication Name______________________Date__________________Dosage __________________

D. 1. Is client on any type of restricted/special diet? Yes _____ No _____

If yes, please describe____

2. Does client have any difficulties swallowing Yes ______ No ______

   If yes, please describe ____

3. Are client's teeth intact? Yes ______ No ______

E. Vision - Does client were corrective lenses? Yes _____ No ______

   Is client color blind? Yes ________ No______

   Does client experience any of the following: (check those that apply)

   _______blurred vision ______hemionopsia

F. Surgeries - Has client undergone any surgical procedures? Yes ______ No ______

If yes, please list:

Procedure	Doctor	Date	Location

Were there any complications to any of these surgical procedures? Yes_____ No _____

If yes, please describe ____

G. Allergies - Does client have any allergies? Yes_____ No_____

   If yes, please list: ____

H. Neurological testing - has the client received any of the following neurological examinations?

   CT Scan - Yes ______ No _____ PET Scan - Yes _____ No_____ MRI - Yes _____ No _____

   If yes to any of the above, please complete the following?

   Test Name__________________ Date_____________ Location __________________ Doctor ________________

   Test Name__________________ Date_____________ Location __________________ Doctor ________________

I. Serious Injuries/Accidents - Has client suffered from any serious injuries or accidents? Yes_____ No _____

   If yes, please describe ____

III. Speech/Language Hearing Status

A. 1. Does client have any hearing difficulties? Yes_____ No _____

   2. Has client's hearing been checked recently? Yes _____ No _____

      If yes, date of examination_______________ results __________________ Location_________________________

   3. Does client wear hearing aids? Yes_____ No _____

B. 1. Does client experience any difficulty speaking Yes _____ No _____

If yes, please describe ______________________________

2. Has client received any speech therapy in the past? Yes _____ No _____

If yes, date of last therapy session ______ Location ______________________________

and Therapist name ______________________________

3. Has there been any recent improvement in the client's speech? Yes ____ No _____

IV. Current Functional Status

A. Is client independent in caring for his/her daily needs? Yes _____ No _____

If no, please check any areas of difficulty and describe client's abilities for those areas:

_____ Eating Description ______________________________

_____ Dressing Description ______________________________

_____ Bathing Description ______________________________

_____ Toileting Description ______________________________

_____ Writing Description ______________________________

_____ Transportation Description ______________________________

_____ Reading Description ______________________________

B. Is client able to walk independently? Yes _____ No _____

If no, please check any of the following that apply:

_____ Walks with assistive devices (i.e., cane, walker, crutches)

_____ Wears leg braces

_____ Uses a wheelchair (please check those that apply)

____ part time _____ full time ____ transfers independently

____ transfers with assistance ____ propels chair independently

_____ Requires assistance ascending/descending stairs

C. What is client's occupation? ______________________________

1. Is client presently working? Yes _____ No _____ If yes, where? ______________________________

2. Is client retired? Yes _____ No _____ If yes, where from? ______________________________

V. Social History

A. Childhood

1. Where was client born? ____________________

2. What are client's parents names? Mother ____________________ Father ____________________

3. Does client have siblings? Yes _____ No _____ If yes, how many? _____

   Please list name and area of residence for all living siblings below:

   Name ____________________ Residence ____________________

   Name ____________________ Residence ____________________

   Name ____________________ Residence ____________________

   Name ____________________ Residence ____________________

   Name ____________________ Residence ____________________

4. Does client have any religious affiliation? Yes _____ No _____

   If yes, please list church ____________________ clergy's name ____________________

B. Education/Occupation

1. What is the highest educational level completed by this client? (check one)

   ____ grade school ____high school (or equivalent)

   ____College: associates degree _____ bachelors degree _____ masters degree ____ doctoral degree ____

2. What is client's occupation? ____________________

3. Where has client worked? ____________________

C. Hobbies/Pastimes

1. Does client continue to participate in pastime activities? Yes _____ No _____

2. If yes, please list these activities____________________

3. If no, list any activities that client used to enjoy____________________

D. Marriage/Children

1. Is client married? Yes _____ No _____

   Is spouse still living? Yes _____ No _____

2. Does client have any children? Yes _____ No _____

If yes, list the names and areas of residence:

Name ________________________ Residence ________________________

Name ________________________ Residence ________________________

Name ________________________ Residence ________________________

V. Speech Situations Checklist

Do you experience difficulty speaking when:

1. Ordering in a restaurant? Yes ____ No ____
2. Introducing yourself face to face? Yes ____ No ____
3. Answering the telephone? Yes ____ No ____
4. Introducing one person to another? Yes ____ No ____
5. Buying something from a store clerk? Yes ____ No ____
6. In conversation with a friend? Yes ____ No ____
7. Talking to a stranger? Yes ____ No ____
8. Providing your name over the phone? Yes ____ No ____
9. Saying hello to a friend going by? Yes ____ No ____
10. Reading aloud? Yes ____ No ____
11. Talking with you barber/beautician? Yes ____ No ____
12. Telephoning for an appointment or information? Yes ____ No ____
13. Giving directions or information to a stranger? Yes ____ No ____
14. Conversation with spouse/best friend? Yes ____ No ____
15. Other (please specify) ____

____

VI. Attitudes/Feelings About Communication

Circle T if statement is generally true for you and circle F if statement is generally false for you.

1. T F I usually feel that I am making a favorable impression when I talk.
2. T F I find it easy to talk with almost anyone.
3. T F I find it very easy to look at my audience when talking to a group of people.
4. T F A person who is my boss/superior is hard to talk to.

5. T F Some words are harder than others for me to say.

6. T F I find it easy to keep control of my voice when speaking.

7. T F Although I have tried therapy in the past, no one has been able to help my speech.

8. T F I am sometimes embarrassed by the way I talk.

9. T F I often feel nervous while talking.

10. T F I believe that I am in control of my speech.

VII. History/Description of Speech

A. Did/does anyone in you family stutter? Yes _____ No _____

B. At what age did you notice stuttering behaviors? ____________________

C. Have you tried speech therapy in the past? Yes _____ No _____

If yes, complete the following

Where ____________________

When ____________________

For how long ____________________

Name of Therapist ____________________

Summarize the focus of this therapy ____________________

____

D. Briefly describe you speech patterns ____________________

____

E. Does anything seem to make your speech better or worse? Yes _____ No _____

If yes, please describe____________________

____

VI. Would you like us to send a copy of the report to anyone? (Please List Name & Addresses)

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