University of North Texas
Speech and Hearing Center
Adult Speech-Language Evaluation
Case History Form

Name:______________________________Birthdate:__________Age:______Gender: M F

Address:______________________________________ Home Phone:_________________

City:________________________________State:______________Zip_______________

Next of kin:____________________________________Phone:______________________

Referred by:_____________________________________Relationship________________

Insurance information:____

Person completing form ______________________ self ______ other ______________

Reason for Evaluation: Please describe your communication difficulty (you/your refers to the client)

How long have you been experiencing problems with your communication?

Please describe how your communication problems are impacting your daily life.

Have you been treated by a speech pathologist for this problem?
______No _____Yes Where?____
Length of treatment____________________Reason treatment stopped__________________
Other treatment (describe)____
Is your primary care physician aware of your communication problems?_____Yes______No
Name of Primary Care Physician_________________________ Phone:_________________

Background Information: Please tell us a little about yourself

Highest education obtained:__________________ Year______

Are you currently a student? ____No ____Yes (Major)____________________________

Current Employment____Full-time ____Part-time_____Retired______Not employed

Vocation:____

Employer:____

Persons authorized to receive medical information about you:

Name Relationship

____

____

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____

Please describe your interests and activities:_____________________________________

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Health/Medical Information

Please describe any medical conditions you believe might be causing your communication problems____

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Do you have a history of any of the following? (Check all that apply):

_____Hearing problems ______Chronic sinus problems

_____Stroke ______Frequent laryngitis

_____Brain injury ______Respiratory problems/COPD

_____Neurologic disease ______Tumors of mouth, neck, throat

_____Brain tumor ______Head/neck surgery

_____Paralysis or muscle weakness ______Immune deficiency

_____Coordination problems ______Learning disabilities

_____Balance problems ______Depression/Emotional disorder

_____Seizure disorder ______Other (describe)_________________________

_____Chemical dependency ______Other (describe)_________________________

Please list medications you are currently taking

Medication Name Dosage Reason prescribed

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Please describe your tobacco/alcohol habits
Tobacco_____Do not use______Use less often than daily_______Daily use
Alcohol______Do not use______Use less often than daily_______Daily use
Do you wear a hearing aid?_______yes ______No
Do you wear dentures?_______Yes______No
Do you wear glasses?_______Yes ______No

Please describe specific information you would like to obtain during this evaluation.

Please describe any questions you would like answered regarding your communication.

Please describe specific ways you would like your communication to improve.