

Boston University

College of Health and Rehabilitation Sciences

Speech, Language and Hearing Center
635 Commonwealth Avenue
Boston, MA 02215
(617) 353-3188

Date Received at BU: _____

Adult Case History Form

Contact Information

Full Name: _____

Home Address: _____
Street Address

City State Zip

Home Telephone: _____

Work or Cell Telephone: _____

E-Mail Address: _____

Gender: Male | Female

Date of Birth: _____
Month | Day | Year

Date form was completed: _____

Purpose of Visit

What would you like to be seen for

Diagnostic Evaluation Therapy Both (Diagnostic and Therapy)

List the problems with which you want help

1. _____

2. _____

3. _____

Referral From
(if applicable): _____
Name Phone

Background Information

Occupation: _____

Marital Status: Single | Married | Separated | Divorced

Education Completed: _____

Primary Language Spoken: _____

Name of spouse/nearest relative/parents (if under 21): _____

If spouse, relative or parents is at the same address as above please check here

Address: _____
Street Address

City

State

Zip

Phone Number: _____

Name and age of children: _____

1. Please describe the communication problem you are having.

2. When and how did the difficulty begin? Did the problem begin suddenly or gradually?

3. How would you rate the severity of the problem now?

Mild

Moderate

Moderately Severe

Severe

4. Describe what you think may have caused this problem, and/or any situation or condition that you associate with this problem.

5. Describe any changes or variations that you have noticed in the problem since it began

Background Continued

6. Have you had a speech and language evaluation/treatment at any other Hospital or clinic?
Y | N (if yes, please fill in the below.)

Name of Clinic: _____

Address: _____

Date of Evaluation _____

Type of Treatment _____

7. Have you seen any other specialist regarding your problem?

Specialist Name: _____

When: _____

Facility Name: _____

8. Describe anything you have done to improve your problem.

Speech , Language, Hearing and Cognitive Questionnaire

1. Please check any of the following characteristics that are true for you now:

- have difficulty recalling names of people, objects etc.
- have difficulty speaking in complete well-organized sentences
- have difficulty swallowing foods or liquids
- mispronounce or omit a sound or sounds while speaking
- have a problem pronounced foreign or regional accent
- have difficulty coordinating voice, tongue, lips etc to produce speech
- have a drooling problem while talking
- feel overly tense while talking
- have a stuttering or stammering while talking
- repeat sounds, words, parts of words or phases in regular talk
- have difficulty, or pause, before saying certain words or sounds
- hold breath while talking
- seem to be out of breath while talking
- notice voice hoarse most of time
- have a pain in throat while speaking
- notice voice sounds like it is coming through the nose
- notice voice always sounds like I have a cold
- notice that people complain that I always talk to softly or to loud
- notice voice is abnormally low-pitched or high pitched
- notice voice is worse at certain times of the day or certain seasons
- feel my speech is normal
- have problems remembering events or appointments
- have problems solving daily problems
- have problems organizing complex events (e.g. trip planning)
- have problems with reading and/or writing (briefly describe)

_____ Have problems understanding other people (briefly describe)

2. Please check any of the following characteristics that are true of your hearing now.
- _____ have no difficulty hearing
 - _____ have hearing loss in my Right Left Both ears
 - _____ can hear but cannot understand when people talk to me
 - _____ prefer having the television turned louder than those around me
 - _____ have difficulty hearing in a one-to-one situation
 - _____ have difficulty hearing in groups
 - _____ have difficulty hearing on the phone

3. When was your last hearing test
 When: _____ Where: _____

4. Do you wear hearing aid(s) or an implanted hearing device?
 _____ Yes _____ No
 If yes, please provide a brief description of your hearing aid and/or cochlear implant use:

5. Are there any difficulties with your device that you would like us to know about?

6. Have you been exposed to loud sounds (gunfire, loud music, heavy machinery, power tools, etc.)? Yes | No
 Where: _____

Medical History

1. List all present disabilities or health problems:

2. Are you currently under medical treatment or medication? (List or Describe)

Medical History Continued

3. List and describe any hospitalization, operations or accidents? Please indicate dates:

4. Please indicate if you have had any of the following:

_____ adenoidectomy	_____ lead poisoning
_____ allergies	_____ measles
_____ asthma	_____ meningitis
_____ chicken pox	_____ mumps
_____ colds (frequent)	_____ pneumonia
_____ croup or excessive coughing	_____ ringing in ears
_____ diabetes	_____ seizures
_____ dizziness	_____ or convulsions
_____ ear ache or ear infections	_____ sinus trouble or post nasal drip
_____ fainting spells	_____ sore throat (frequent)
_____ fever (high)	_____ thyroid disease
_____ headaches	_____ tuberculosis
_____ heartburn	_____ other: _____
_____ laryngitis (frequent)	_____

Family Medical History

Please indicate if you or any relatives on either side of the family have had the following:

	Self	Mother's Side	Father's Side
Behavior problems, including hyperactivity	_____	_____	_____
Drug or Alcohol abuse	_____	_____	_____
History of smoking	_____	_____	_____
Emotional or psychiatric problems	_____	_____	_____
Learning problems	_____	_____	_____
Ambidexterity or left hand preference	_____	_____	_____
Mental Retardation	_____	_____	_____
Other Neurological problems	_____	_____	_____

Developmental and Educational History

1. Describe any developmental problems during infancy or early childhood (i.e. late in walking, feeding problems, allergies, late in talking etc.)

2. Describe any learning or reading problems you experienced as a child or are currently experiencing:

3. Have any other members of your family had speech and/or hearing difficulties? Please describe

Personal History

1. What are your hobbies/leisure activities?

2. Is there anything else you think may be important or would like to indicate or think may be important?

If, in order to help you, it would be appropriate to send or receive reports from other education / health care professionals, please indicate your permission by signing the provided consent form.