Aphasia Resource Center

635 Commonwealth Avenue, 6th floor
Boston, MA 02215
Tel: (617) 353-0197; Fax: (617) 358-5460

Date Received at BU ARC: _____

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

Name: _____ File Number (if applicable): _____

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)

Name: _____ File Number (if applicable): _____

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

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			

Name: _____ File Number (if applicable): _____

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.

1. Name of person who completed this case history form (or indicate self):

Name: _____ File Number (if applicable): _____