



**SOUTHEASTERN  
LOUISIANA UNIVERSITY**

**Adult Case History Form**

**General Information**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City/State Zip Code

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Campus Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City/State Zip Code

Referred by: \_\_\_\_\_ Reports to be sent to: \_\_\_\_\_

Name and relationship of person filling out form: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City/State Zip Code

**Employment History (most recent)**

	<u>Place</u>	<u>Date</u>	<u>Position</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

**Physicians**

	<u>Name</u>	<u>Address</u>	<u>Phone</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**Marital Status**

Spouse: \_\_\_\_\_ Age: \_\_\_\_\_  
Children: Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Other persons living in home and relation to family: \_\_\_\_\_

**Educational History**

	<u>School</u>	<u>Location</u>	<u>Highest grade completed or degree</u>	<u>Date</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Forms IV Disk contents-Adult case history 8/17/2006

**DESCRIBE YOUR PRESENT HEALTH:** \_\_\_\_\_

Do you have a history of medication or treatment of:

YES      NO

YES      NO

- Allergies
- Sinus Infection
- Anemia
- Asthma
- Broken Nose
- Bronchitis
- Chronic laryngitis
- Cleft palate
- Diabetes
- Chronic ear infections
- Hearing problem
- Rheumatic fever
- Emotional difficulty
- Tobacco use:  
-How much per day?
- Alcohol use:  
-How much per day?

- Glandular Imbalance
- Hyperthyroidism
- Hypothyroidism
- Heart trouble
- Numbness
- Paralysis/paresis
- Mouth-breathing
- Mumps
- Pneumonia
- Poliomyelitis
- Scarlet fever
- Tremors
- Visual problems
- High fever
- Swallowing difficulties
- Other: \_\_\_\_\_

If the answer to any of the above items is "yes", give the relevant details (e.g., how frequent are these episodes, how severe are these episodes, and treatment you are receiving):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List periods of hospitalization or medical treatment:

<u>Hospital/ City/ State</u>	<u>Date/ Reason</u>
1. _____	_____ _____
2. _____	_____ _____
3. _____	_____ _____

List all surgical procedures:

\_\_\_\_\_  
\_\_\_\_\_

List all prescription and nonprescription medication used over the past year (name the type if you can not remember the generic name, i.e. aspirin, allergy pills, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a neurological examination? \_\_\_\_\_ If so, by whom, when, and where?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you speak a language other than English, please state the language \_\_\_\_\_ Are you bilingual? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe in your own words the nature of your communication problems.

\_\_\_\_\_  
\_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

When did you first notice its presence? \_\_\_\_\_

What were the circumstances?

\_\_\_\_\_  
\_\_\_\_\_

Have any members of your family had hearing or speech problems?

\_\_\_\_\_  
\_\_\_\_\_

How do you feel your speech problem has affected your social life?

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How do you feel your speech problem has affected your occupation?

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If you didn't have a speech problem, how would your life be different?

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Describe the reaction of people, including you immediate family, to your speech problems.

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Do any specific communication situations present difficulty for you? \_\_\_\_\_

Explain:

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Do you avoid any communication situations? \_\_\_\_\_ Explain: \_\_\_\_\_

List interests you have or activities you engage in (clubs, hobbies, organizations, etc.):

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What, if anything, have you tried to do to correct the speech problem?

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Are you coming to the Speech and Hearing Clinic on your own?

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On the advice of another? \_\_\_\_\_

Have you ever received any prior speech and hearing evaluation? \_\_\_\_\_

Therapy? \_\_\_\_\_

Agency: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Dates: \_\_\_\_\_ Dates: \_\_\_\_\_

Results: \_\_\_\_\_ Results: \_\_\_\_\_

Did prior evaluation or therapy relate to the present problem?

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How effective has prior therapy been in helping you with your problem (what helped the most/least)?

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If therapy was terminated, describe why: \_\_\_\_\_

How long has the present problem existed? \_\_\_\_\_

Has the nature of the problem changed at any time? \_\_\_\_\_

Explain: \_\_\_\_\_

List any additional sources of information, which may be helpful to us in assisting with your problem:

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