

**THE WALDRON COLLEGE OF HEALTH AND HUMAN SERVICES  
Radford University Speech-Language and Hearing Clinic  
Radford University  
P. O. Box 6961  
Radford, VA 24142  
(540) 831-7166  
Fax: (540) 831-7669**

**Adult Case History Form  
Speech and Language**

General Information:

Date form completed: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to adult: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Children (Include names, gender, and ages):

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

Who lives in the home?

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

What languages do you speak? If more than one, which one is your primary language?

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What was the highest grade, diploma, or degree earned?

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Do you have a speech-language problem? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe your speech-language problem.

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When did you first notice the problem? \_\_\_\_\_ .  
Did it begin suddenly? \_\_\_\_\_ gradually? \_\_\_\_\_ .

What do you think may have caused the problem?

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Has the problem changed since it was first noticed? If yes, describe.

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Have you seen any other speech-language pathologists? Who and when? What were their conclusions or suggestions?

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Have you seen any other specialists (physicians, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions.

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Are there any other speech, language, learning, or hearing problems in your family? If yes, please describe.

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AUDITORY HISTORY:

Do you have a hearing problem? Yes No . If “yes”, continue:

Which ear is affected? Right . Left . Both .

When did you first notice your hearing loss?

Did it begin suddenly? \_\_\_\_\_ gradually? \_\_\_\_\_

Has your hearing loss gradually gotten worse? Yes No \_\_\_\_\_

Does your ability to hear change from day to day? Yes No \_\_\_\_\_

What do you think caused your hearing loss?

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

Do you hear sounds (“tinnitus”) in your ears or head? Yes No \_\_\_\_\_

Do you ever experience dizziness, balance problems, or spinning sensation?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If “yes”, please describe fully

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

**Medical History:**

Provide the approximate ages at which you suffered the following illnesses and conditions:

<u>Illness/Condition</u>	<u>Age</u>	<u>Illness/Condition</u>	<u>Age</u>	<u>Illness/Condition</u>	<u>Age</u>
Adenoidectomy		Encephalitis		Noise Exposure	
Allergies		German Measles		Otosclerosis	
Asthma		Headaches		Pneumonia	
Chicken Pox		Hearing Loss		Seizures	
Colds		High Fever		Sinusitis	
Convulsions		Influenza		Tinnitus	
Croup		Mastoiditis		Tonsillectomy	
Dizziness		Measles		Tonsillitis	

Draining Ear		Meningitis		Other:	
Ear Infections		Mumps		Other:	

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Please describe your present general health. \_\_\_\_\_

\_\_\_\_\_

Describe other major health concerns. \_\_\_\_\_

\_\_\_\_\_

Have you been hospitalized within the past five years? Yes \_\_\_ No \_\_\_ If yes, describe

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check any of the following assistive devices that you use:

. \_\_\_ wheelchair     . \_\_\_ walker     . \_\_\_ quadcane/hemiwalker     . \_\_\_ cane

Do you have any eating or swallowing difficulties? If yes, describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications you are taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you having any negative reactions to these medications? If yes, describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe any allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

