HARDIN-SIMMONS
UNIVERSITY
SPEECH-LANGUAGE PATHOLOGY

CASE HISTORY (ADULT) **Date completed**: ______________________________

CLIENT'S NAME: ______________________________________ DOB: ____

ADDRESS: ____ CITY, STATE, ZIP: ____________________________________

HOME PHONE: ____ CELL PHONE: ____

WORK PHONE: ____ EMAIL: ____

FAMILY PHYSICIAN: ___________________________________ PHONE #: ____

CONTACT PERSON: ____________________________________ RELATIONSHIP: ______________________________________

WORK PHONE: ____ CELL PHONE: ____

EMAIL: ____

Are you: ☐ Single ☐ Widowed ☐ Divorced ☐ Married

Check the ways we may communicate with you: ☐ Cell Phone ☐ Work Phone ☐ Email May we leave a message? ☐ Yes ☐ No

How did you hear about the HSUSLC? ____

What language(s) do you speak? ____

Which is your dominant language? ____

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

What is your current occupation?____

GENERAL INFORMATION

Describe your concern that brought you to the clinic today.

What do you think may have caused the problem?

Has the problem changed since it was first noticed? ☐Yes ☐ No If you answered yes, please explain.

Have you previously seen a speech-language pathologist? ☐ Yes ☐ No If answered yes, where?_________________________

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MEDICAL HISTORY

Please check if you have ever been diagnosed with any of the following:

	Aphasia		Apraxia		COPD
	Covid 19		Dementia		Diabetes
	Dysarthria		Dysphagia (swallowing disorder)		GERD (acid reflux)
	Glaucoma		Hearing Loss		Heart Attack
	High Blood Pressure		Influenza		Meningitis
	Parkinson's Disease		Pneumonia		Seasonal allergies
	Stroke		Tinnitus (ringing or buzzing in ears)		Thyroid problems
	Transient Ischemic Attacks (TIA's)		Traumatic Brain Injury (TBI)		
	Other:				

Please check all that apply.

	Chemotherapy/Radiation		Dentures		Difficulty focusing
	Dizziness		Frequent falls		Glasses
	Headache		Hearing Aids		Memory loss
	Noise exposure		Smoking		Weakness on one side
	Word recall difficulties				

Please provide any information on items checked above.

Please list all medications you are currently taking.

Name of Person Completing Form ____________________________________ Relationship to Client _________________

Signature ____ ***Date*** ______________________________