WORCESTER STATE UNIVERSITY

486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 Fax: 508-929-8175

Date Received: ____________
(Office Use Only)

SPEECH–LANGUAGE–HEARING CENTER

Adult Case History Form (Confidential)

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports from previous agencies with this case history form. Once we have received requested reports, an evaluation/treatment will be scheduled as soon as an opening becomes available.

Personal Information

Date:__________

Name:____________________________ Date of Birth:______________ Age:_______ Sex:__________

Address:____
(# Street)

____
City State Zip Code

Home Phone:____________________ Cell Phone:____________________ Business Phone:____________________

Email:________________________ Fax:____________________

Preferred method of communication: Email ☐ Telephone ☐

Are you a Worcester State University **faculty / staff / student** ? If yes, circle one.

Name of person giving information, if different from above:____________________________

Relationship to client:____

Referred by:____

Reason for referral:____

Have you been evaluated or treated at this clinic before? Yes ☐ No ☐

If yes, when and for what reason?____

____

Person responsible for payment of fees:____

Family Information

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Name of Spouse:____

Children's names and ages:____

____

Other persons living in your home and their relationship to you:______________________________

____

Educational/Occupational/Social Information

Highest level of education completed:____

Occupation:____

Current Employer:____ Business Phone:____________________

What do you like to do in your spare time?____

Medical Information

General health is: Good ☐ Fair ☐ Poor ☐

Please indicate whether or not you have had any of the following illnesses or conditions:
(For any "yes" responses, please explain below)

Condition	Yes	No
Accidents	Yes ☐	No ☐
Adenoidectomy	Yes ☐	No ☐
Allergies	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Behavior Difficulties	Yes ☐	No ☐
Cancer/Tumor	Yes ☐	No ☐
Concussion	Yes ☐	No ☐
Dementia	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐
Ear Infections	Yes ☐	No ☐
Emotional Difficulties	Yes ☐	No ☐
Encephalitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Head Injury	Yes ☐	No ☐
Heart Problem	Yes ☐	No ☐
High Fever	Yes ☐	No ☐
Meningitis	Yes ☐	No ☐
Multiple Sclerosis	Yes ☐	No ☐
Neurological	Yes ☐	No ☐
Noise Exposure	Yes ☐	No ☐
Otosclerosis	Yes ☐	No ☐
Paralysis	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐
Psychiatric Diagnosis	Yes ☐	No ☐
Sinusitis	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Surgery	Yes ☐	No ☐
Thyroid Problem	Yes ☐	No ☐
Tonsillectomy	Yes ☐	No ☐
Tonsillitis	Yes ☐	No ☐
Voice Problems	Yes ☐	No ☐
Other	Yes ☐	No ☐

If you answered yes to any of the above items, please explain in detail:____

____

Please describe any other medical conditions you may have that are not listed above:____

____

Current Medications: (prescribed, over-the-counter, herbal)____

____

Primary Care Physician's Name:____

Address:____Phone Number:____________________

Other Health Care Providers (please list name, specialty and phone number):____

____

Speech and Language History

What is the predominant language spoken in the home?____________________________

What language(s) do you speak in other settings (e.g., church, work, social settings)?____

____

What language(s) do you read and write?____

Describe your communication problem:____

____

____

____

Why are you concerned about your communication?____

____

What do you think caused your communication difficulties?____

____

____

Are there any other family members with communication difficulties? Yes ☐ No ☐

If so, list relationship and explain difficulty:____

____

____

Have you ever attended speech-language-hearing therapy? Yes ☐ No ☐

If so, when? ____

Speech-language pathologist's name and address ____

____

How do you communicate with others? Please check all that apply.

Speech ☐ Gestures ☐ Communication Book ☐ Writing ☐ Sign Language ☐

Voice Output System (Mini-Mercury, Dynamite, etc.)____

Do you have any difficulty with swallowing? Yes ☐ No ☐

If so, please explain and list your current diet:____

____

Do you use any of the following assistance devices?

Wheelchair ☐ Walker ☐ Cane ☐ Glasses ☐ Other ________________________

Auditory History

Do you have a hearing problem? Yes ☐ No ☐ In which ear? Right ☐ Left ☐ Both ☐

When was the onset of your hearing loss? ____________________ Was the onset: Sudden ☐ Gradual ☐

Has your hearing loss been gradually progressive in nature? Yes ☐ No ☐

Does your hearing fluctuate from day to day? Yes ☐ No ☐

What was the cause of your hearing loss?____

____

Do you experience any sounds ("tinnitus") in your ears or your head? Yes ☐ No ☐

Do you ever experience dizziness, balance problems or spinning sensations? Yes ☐ No ☐

If yes, please describe fully:____

____

Do you wear a hearing aid? Yes ☐ No ☐

Audiologist's name and address (if applicable): ____

Otolaryngologist's (ENT) name and address (if applicable): ____

Summary

Provide additional information that you believe might be helpful in the evaluation or remediation process. Attach additional pages if needed. ____

____

Signed:____ Date:____________________

How did you hear about our services?

☐ Radio
☐ Mailing
☐ Alumni
☐ Family/Friend
☐ Website
☐ WSU posting
☐ Senior Presentation
☐ Television
☐ Newspaper
☐ Health Fair
☐ Higher Education Consortium of Central Massachusetts (HECCMA)
☐ WSU Employee
☐ Other:____________________

Reminder

Before returning this paperwork to Worcester State University Speech-Language-Hearing Center, have you:
Completed this case history in its entirety?
Read and signed the following release forms?
• Authorization for observation, audio/DVD recording, and use of email/text messaging ☐
• Authorization for Release of Information ☐
Contacted other agencies to have them forward reports to you or directly to the Worcester State University Speech-Language-Hearing Center?

For additional information, please contact:

Ann T. Veneziano-Korzec, M.S., CCC-SLP , Director • 508-929-8055

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_______ Diagnostic Evaluation
_______ Therapy

Date Received: ____________
(OFFICE USE ONLY)

WORCESTER STATE UNIVERSITY

Name: ______________________________

SPEECH–LANGUAGE–HEARING CENTER
486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 • Fax: 508-929-8175

DOB: ______________

Adult Fluency: Addendum to Adult Case History Form *(confidential)*

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports from previous agencies with this and the case history form. Once we have received requested reports, an evaluation/treatment will be scheduled as soon as an opening becomes available.

1. When was your stuttering first noticed? ______________________________
   By whom? ______________________________

2. What do you believe caused your stuttering? ______________________________

3. Has your stuttering changed since it began? Yes ☐ No ☐
   If yes, please explain. ______________________________

4. List situations in which your stuttering is worse. ______________________________

5. List situations in which you hardly stutter. ______________________________

6. Does your stuttering affect your ability to interact with others in school or at work? Yes ☐ No ☐
   If yes, please explain. ______________________________

7. Does your stuttering affect your ability to interact with others socially? Yes ☐ No ☐
   If yes, please explain. ______________________________

8. Have you ever avoided speaking because of your stuttering? Yes ☐ No ☐
   If yes, please explain. ______________________________

9. Do you use a fluency facilitative device, such as the Speech Easy or Fluency Master?

Yes ☐ No ☐

If yes, please explain: ____________________

____

10. Why are you seeking therapy at this time? ____________________

____

____

11. Is there anything you do that helps you when you stutter? Yes ☐ No ☐

If yes, please explain. ____________________

____

Please answer questions 12 and 13 only if you have had previous therapy.

12. What have you found most helpful in your previous therapy experiences? ____________________

____

____

13. What have you found least helpful in your previous therapy experiences? ____________________

____

____

14. Please describe any other concerns that you have at this time. ____________________

____

____

15. What are you hoping will happen as a result of therapy? ____________________

____

____

Department of Communication Sciences and Disorders
Phone: 508-929-8055
Fax: 508-929-8175

Authorization for Observation and Audio/Video Recording

I, ____consent to the following that I have checked below for____ (please check all that apply)
(Client's Name)

______I consent and authorize the taking of photographs, audio and/or video recording as well as closed circuit televised monitoring of the client specified above (e.g., client and persons associated with the client), by the Worcester State University Speech-Language-Hearing Center (WSU-SLHC). I understand that the WSU-SLHC is an educational facility and therefore consent that the visual and audio displays as described above may be used for educational training or treatment purposes including (please initial all for which you give consent):

___ (1) Case managers, undergraduate and graduate students associated with the Worcester State University Communication Sciences & Disorders Department;
___ (2) Other professionals, such as speech-language pathologists, audiologists, educators, and administrators,
___ (3) Published or professional journals;*
___ (4) Professional or educational conferences.*

* Names of participants in the recording will not be disclosed

______I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow qualified professional personnel and students connected with the WSU Department of Communication Sciences & Disorders and SLHC to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors or by closed circuit television for professional purposes.

_____I consent and authorize the person (s) listed below to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors.

______________________________ ______________________________
______________________________ ______________________________

________________________ ________________ ________________________
Client or Parent/Legal Guardian Date Case Manager

Revised/Fall 2016

486 Chandler Street • Worcester, MA 01602-2597

Speech-Language-Hearing Center • 508-929-8055 • Fax: 508-929-8175

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT'S NAME: ______________________________________ DATE OF BIRTH __________________

CLIENT'S ADDRESS: ____

____

I hereby authorize Worcester State University Speech-Language-Hearing Center to:

OBTAIN FROM: NAME OF FACILITY ____

ATTENTION OF: ____

ADDRESS STREET AND NO. ____

CITY/TOWN ____

I herby authorize Worcester State University Speech-Language-Hearing Center to:

FURNISH TO: NAME OF FACILITY ____

ADDRESS STREET AND NO. ____

CITY/TOWN ____

The following information concerning the above client pertaining to services provided on or about

DATE ____

INFORMATION REQUESTED____

____

RESTRICTIONS (if any) ____

____

_________________________ ____

Date Signature of Client

_________________________ ____

Date Signature of Parent or Guardian

____

Relationship to Client