



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

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

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)

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

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?

- |  |  |
|--|--|
| <input type="checkbox"/> Radio               | <input type="checkbox"/> Television  |
| <input type="checkbox"/> Mailing             | <input type="checkbox"/> Newspaper   |
| <input type="checkbox"/> Alumni              | <input type="checkbox"/> Health Fair   |
| <input type="checkbox"/> Family/Friend       | <input type="checkbox"/> Higher Education Consortium of Central Massachusetts (HECCMA) |
| <input type="checkbox"/> Website             | <input type="checkbox"/> WSU Employee  |
| <input type="checkbox"/> WSU posting         | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Senior Presentation |  |

## 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



**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 hereby 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