UNIVERSITY OF SOUTH CAROLINA

Montgomery Speech, Language, and Hearing Center
803.777.2614 (MAIN LINE)
803.777.3081 (FAX)

ADULT CASE HISTORY FORM

PLEASE FILL OUT EACH SECTION COMPLETELY

PATIENT INFORMATION DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

RACE/ETHNICITY: _____ GENDER: _____

ADDRESS: _____ CITY/STATE: _____ ZIP CODE: _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

OCCUPATION (IF RETIRED, PREVIOUS OCCUPATION) _____

DATE OF RETIREMENT: _____ HIGHEST LEVEL OF EDUCATION: _____

REFERRED BY:_____PHYSICIAN'S NAME: _____

PERSON COMPLETING THIS FORM: _____ RELATIONSHIP TO CLIENT:_____

SOCIAL HISTORY

SINGLE ☐ MARRIED ☐ DIVORCED ☐ SPOUSE/PRIMARY CAREGIVER'S NAME:_____

WHO LIVES AT HOME WITH YOU? _____

LIST OTHER LANGUAGES SPOKEN IN THE HOME: _____

DOES YOUR JOB OR HOBBIES REQUIRE USE OF YOUR VOICE? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ INSURANCE ID NUMBER:_____
NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CARRIER: _____ INSURANCE ID NUMBER: _____
NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

HEALTH HISTORY

WHAT IS YOUR REASON FOR TODAY'S VISIT? _____

HOW IS YOUR GENERAL HEALTH? (PLEASE CIRCLE YOUR ANSWER)

EXCELLENT GOOD FAIR POOR

PRIMARY DOCTOR: _____ PHONE NUMBER: _____

ENT: _____PHONE NUMBER: _____

CARDIOLOGIST: _____PHONE NUMBER: _____

NEUROLOGIST: _____ PHONE NUMBER: _____

DO YOU HAVE ANY METAL IMPLANTS? YES ☐ NO ☐ DATES: _____

PLEASE CHECK ALL THAT APPLY AND PROVIDE DATE OF ONSET:

	YES	NO	DATE MM/YYYY		YES	NO	DATE MM/YYY
ALLERGIES				HEART CONDITION			
ANOXIA OR BREATHING DIFFICULTIES				HIGH BLOOD PRESSURE			
ASTHMA				LOW BLOOD PRESSURE			
CANCER				PNEUMONIA			
DENTAL PROBLEMS				PARALYSIS			
DIABETES				STROKE			
EPILEPSY/SIEZURES				SWALLOWING DIFFICULTIES			
FREQUENT COLDS				THYROID CONDITION			
HEAD INJURY				TUBE FEEDING			
HEARING PROBLEMS				VIRAL INFECTION			
VISION PROBLEMS				EXTENDED HOSPITALIZATION			
EXCESSIVE BLEEDING				MIGRAINE HEADACHES			
SURGERIES/INVASIVE PROCEDURES				TOBACCO USE			

FOR ALL CONDITIONS MARKED "YES," PLEASE PROVIDE MORE INFORMATION (EG, TYPE, TREATMENT, ETC):_____

_____

_____

_____

PLEASE LIST ANY OTHER CONDITIONS: _____

_____

MEDICATIONS

PLEASE LIST THE **NAME** AND **DOSAGE** OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING, AND FOR **WHAT ILLNESS** THE MEDICINE IS PRESCRIBED (INCLUDE OVER-THE-COUNTER MEDICATIONS, OXYGEN, INHALERS, VITAMINS, AND HERBALS)

NAME OF MEDICATION	DOSAGE	ILLNESS/CONDITION

DO YOU HAVE ANY ALLERGIC REACTIONS? IF SO, WHAT ARE YOUR SYMPTOMS? _____

HEARING AID & COCHLEAR IMPLANT INFORMATION

HAVE YOU HAD A HEARING EVALUATION? YES☐ NO☐ NAME OF AUDIOLOGIST: _____

REPORTED RESULTS: _____

HAVE YOU EVER WORN HEARING AIDS? YES☐ NO☐

DO YOU CURRENTLY WEAR HEARING AIDS? YES☐ NO☐ IF YES, WHICH EAR? RIGHT☐ LEFT☐

WHERE DID YOU RECEIVE YOUR HEARING AIDS?_____

DO YOU USE A COCHLEAR IMPLANT (CI)? YES☐ NO☐

IF YES, WHAT DEVICE DO YOU WEAR? ADVANCED BIONICS☐ COCHLEAR☐ MED-EL☐

WHO WAS YOUR IMPLANT SURGEON AND WHAT WAS THE SURGERY DATE?_____

WHICH EAR WAS IMPLATED? RIGHT☐ LEFT☐

WHO WAS YOUR IMPLANT AUDIOLOGIST?_____

ARE YOU RECEIVING SPECIAL HEARING IMPAIRMENT SERVICES? YES☐ NO☐

THERAPISTS NAMES:_____

PLEASE INDICATE ANY PERSONAL HISTORY OF THE FOLLOWING:

	YES	NO
DO YOU HAVE A HISTORY OF EAR DISEASE?		
DO YOU HAVE A FAMILY HISTORY OF HEARING LOSS?		
DO YOU HAVE DIZZINESS, VERTIGO OR LOSS OF BALANCE?		
DO YOU HAVE ANY TINNITUS (RINGING, HISSING, BUZZING IN YOUR EARS)?		
DO YOU HAVE A HISTORY OF NOISE EXPOSURE?		
ANY ACTIVE DRAINAGE FROM THE EAR WITHIN THE LAST 90 DAYS?		
ANY HISTORY OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS WITHIN THE LAST 90 DAYS?		
HAVE YOU EVER HAD A TRAUMA OR BLOW TO YOUR HEAD?		

INDICATE ANY FAMILY HISTORY OF THE FOLLOWING SPEECH, LANGUAGE, HEARING OR LEARNING DIFFICULTIES:

	YES	NO	RELATIONSHIP
DIFFICULTY PRODUCING A FEW SOUNDS			
SPEECH DIFFICULT TO UNDERSTAND BY OTHERS			
STUTTERING			
HEARING LOSS			
LEARNING DISABILITY			
READING			
WRITING			
SPELLING			
DIFFICULTY UNDERSTANDING SPOKEN LANGUAGE			
GENETIC DISORDER			

NAME OF GENETIC DISORDER (IF APPLICABLE): _____

_____

HANDEDNESS (RIGHT OR LEFT) FOR: WRITING_____ THROWING_____ EATING _____

SERVICES CURRENTLY RECEIVED: SPEECH THERAPY: YES ☐ NO ☐ PHYSICAL THERAPY: YES ☐ NO ☐

OCCUPATIONAL THERAPY: YES ☐ NO ☐ VOCATIONAL REHABILITATION: YES ☐ NO ☐

DESCRIBE YOUR COMMUNICATION DIFFICULTY: _____

_____

_____

WHEN DID YOU FIRST NOTICE A CHANGE IN YOUR COMMUNICATION SKILLS? _____

_____

_____

HAS YOUR COMMUNCATION PROBLEM CHANGED SINCE ITS ONSET? YES ☐ NO ☐

IF SO, HOW HAS IT CHANGED? _____

_____

DOES YOUR PROBLEM CHANGE THOUGHOUT A SINGLE DAY? YES ☐ NO ☐

IF SO, HOW DOES IT CHANGE? _____

_____

WHAT ARE YOUR CURRENT AND/OR FUTURE VOCATIONAL GOALS? _____

_____

HAVE YOU HAD SPEECH THERAPY BEFORE? YES ☐ NO ☐ WAS IT HELPFUL? YES ☐ NO ☐

WHAT DO YOU HOPE TO GAIN FROM THERAPY AT THIS TIME IN YOUR LIFE? _____

_____

WHAT QUESTIONS WOULD YOU LIKE ANSWERED? _____

_____

_____