California State University, Fresno
Speech, Language and Hearing Clinic

5310 North Campus Drive M/S PH 80
Fresno, California 93740-8019
(559) 278-2422 ◆ Fax (559) 278-5187

ADULT CASE HISTORY

PLEASE PRINT IN INK OR TYPE ALL INFORMATION

General Information **Today's Date: _____**

Please Check One: ☐ Aphasia Group ☐ Heaing Evaluation Diagnostic Individual Speech Therapy

Name: _____ **Date of Birth: _____ Gender: ___**

Address: _____ **Email: _____**

City: _____ **Zip: _____**

Occupation: _____ **Cell Phone: _____**

Employer: _____ **Home Phone: _____**

Please Check One: Single Widowed Divorced

Spouse's Name: _____ **Spouse's Occupation: _____**

Names, ages, and gender of children: _____

_____

Referred By: _____ **Phone: _____**

Address: _____

Have you been tested and/or evaluated at this clinic before? _____

If yes, how long ago was your last visit? _____

Office Use Only:

Date Received: _____

Dates Contacted: _____

Names and relation of other persons living in home: _____

What languages do you speak? _____

What is your primary language? _____

Highest grade completed or degree earned? _____

Describe your speech-language or hearing problem: _____

_____

_____

What do you think caused the problem? _____

_____

_____

When did you first notice the problem? _____

_____

_____

How has the problem changed since you first noticed it? _____

_____

_____

How has your communication problem affected your life? _____

_____

_____

List other speech-language specialists or audiologists you have seen and describe their conclusions or recommendations: _____

_____

_____

List any other specialists (physicians, psychologists, neurologists, etc.) you have seen, and the specialists' conclusions or suggestions: _____

_____

_____

_____

Describe any other speech, language, learning, or hearing problems in your family: _____

_____

_____

_____

Medical History

General Health is: ☐ Good ☐ Fair ☐ Poor

Provide the approximate ages at which you experienced the following illness and conditions:

Adenoidectomy _____	**Allergies** _____	**Asthma** _____
Chicken pox _____	**Colds** _____	**Convulsion** _____
Croup _____	**Diabetes** _____	**Draining ear** _____
Ear Infections _____	**Dizziness** _____	**Epilepsy** _____
Headaches _____	**Encephalitis** _____	**German Measles** _____
Influenza _____	**Hearing Aids** _____	**Heart problems** _____
Meningitis _____	**Hearing Loss** _____	**High fever** _____
Numbness _____	**Mastoiditis** _____	**Measles** _____
Otosclerosis _____	**Mumps** _____	**Noise Exposure** _____
Sinusitis _____	**Paralysis** _____	**Seizures** _____
Tonsillitis _____	**Pneumonia** _____	**Tonsillectomy** _____
Ulcers _____	**Visual Problems** _____	**Glasses** _____
Do you smoke? _____	**How much per day?** _____	

List all prescription and nonprescription medication used during the past year: _____

_____

_____

Describe any eating or swallowing difficulties you have experience: _____

_____

_____

List any major accidents, illnesses, surgeries, or hospitalizations (include dates): _____

_____

_____

_____

Provide any additional information that you might believe to be helpful in the evaluation or remediation process: _____

_____

_____

_____

_____

PLEASE ATTACH ANY REPORT YOU HAVE FROM ANOTHER AGENCY, SCHOOL, OR DOCTOR.

Person completing the form: _____

Relationship to client: _____

Signed: _____ **Date:** _____

****Please Note:** You must complete and sign the attached Observation and Photo/Video Consent statements and return them with your case history form. Thank you for taking the time to fill out the forms completely and accurately.

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Observation Consent

Consent is hereby given to faculty, students and other persons approved by the clinical supervisor at the Language, Speech and Hearing Clinic at California State University, Fresno to observe _____ in the clinic or in off campus settings.

Client Name

The purpose of these observations is to train University Communicative Sciences & Disorders students (both diagnostic and treatment sessions may be observed). Students from other departments studying children and adults with language, hearing, and speech disorders may also watch and listen if the supervisor gives permission.

_____ _____

Parent/Guardian/Self (18 or older) **Date**

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Consent and Release for Photographs or Videotaping

Consent is hereby given to the Speech, Language, & Hearing Clinic, at California State University, Fresno, to take photographs, or videotape of _____. I understand that the photos/videos will be used to train University students and demonstrate department activities to the general public (e.g. CDDS department website or on Professional Health Services building bulletin boards).

I understand that I will be able to view the photographs or videotape if I request to do so.

_____ _____

Parent/Guardian/Self (18 or older) – Print Name **Date**

_____

Signature

Revised 7.15.15