PURDUE
UNIVERSITY

DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES

Adult Speech and Language Case History

Today's Date: ___/___/_____
Month/Day/Year

General Information

Name: ____ Date of Birth: ___/___/_____ Age: ________
Last First Middle Month/Day/Year

Home Address: ____
Street/P.O. Box City State Zip County

Campus Address: ____
Street/P.O. Box City State Zip County

Telephone: (___) ________________________ (___) ________________ (___) ____________________
Home Work Cell

What languages do you speak? ____
If more than one, which is your primary language? ____________________________________

Who referred you to the speech clinic? ____

Name of person filling out this questionnaire: ________________________ Relationship: _____________

Speech-Language History

Please describe the nature of your communication problem, including when you first noticed it and how it has changed since then: ____
____
____
____

What caused the problem:____
____

Have any relatives had speech, language and/or hearing problems? Yes No
If Yes, relationship: ________________________ *Type of problem:* ________________________________

How has the speech-language problem affected your social life and/or occupation:
____
____
____

Describe any specific communication situations that present difficulty for you:
____
____

Describe the reaction of people, including your immediate family to your speech-language problem:
____

Do you avoid any communication situations? Yes No
If Yes, please explain: ____

What, if anything, have you tried to do to correct the speech-language problem?
____

Have you ever had a hearing evaluation? Yes No
If Yes, when and by whom? ____
What were the results? ____

Have you ever had a speech-language evaluation? Yes No
If Yes, when and by whom? ____
What were the results? ____

Have you ever received speech-language therapy? Yes No
If Yes, by whom and what was the duration? ____
What were the goals of therapy? ____
____

What were the results? ____
____

If therapy was terminated, describe why: ____

Please list any additional information that you think may be helpful in assisting with your problem:
____
____
____

Employment History
Please list your most recent information.

Place	Dates	Position

Educational History
Please list your most recent information.

School	Location	Degree	Date

Medical History

Describe your present health: Good Fair Poor

Physician(s)

Name	Specialty	Address	Phone

List all medical diagnoses including dates:
1. ____
2. ____
3. ____
4. ____
5. ____

List all periods of hospitalization for surgical or medical treatment including dates.
1. ____
2. ____
3. ____
4. ____
5. ____

List all health or medical problems experienced over the last 5 years.
1. ____
2. ____
3. ____
4. ____
5. ____

List all medication used over the past year (prescription, over the counter, herbal supplements/alternative medicines)
1. ____
2. ____
3. ____
4. ____
5. ____

Check all that apply to your medical history:

	Yes	No		Yes	No		Yes	No
Allergies			Head injury			Polio		
Anemia			Hearing problem			Poor dentition/Dentures		
Asthma			Heart Trouble			Psychological counseling		
Broken nose			High Blood Pressure					
Bronchitis			Hormone Therapy			Scarlet fever		
Cancer/tumor(s)			Incoordination of face or tongue muscles			Seizures		
Chicken Pox			Influenza			Sinus infection		
Chronic colds/upper respiratory infections			Kidney problems			Smoking: How often:		
Chronic laryngitis			Motor Disorder			Stroke		
Cleft palate			Mouth breathing			Syphilis		
Diabetes			Mumps			Tinnitius (ringins in the ears)		
Diphtheria			Neurological problem			Tremor/twitching		
Dizziness			Noise exposure			Ulcers		
Drinking: How often:			Numbness			Visual problems		
Ear Disease			Paralysis/paresis			Whooping cough		
Emotional difficulty			Parkinson's disease					
Glandular imbalance			Physical defect			Other:		
Glasses			Pneumonia			Other:		

If the answer to any of the above items is "Yes," give the relevant details (e.g., how frequent are these episodes, how severe are these episodes): ____
____
____

Please list the information regarding the most recent exams below:

Type of Exam	Date	Name of Professional	Results
Physical Exam			
Vision Test			
Hearing Test			
Psychological			
Neurological			
Other:			

Social History

Marital Status: Married Never Married Divorced Widowed

Do you have children? Yes No

If yes, please provide information below.

Name	Age	Gender	Name	Age	Gender
		M F			M F
		M F			M F
		M F			M F

List the relation, name and age of other people in the household:

Relation	Name	Age

List your interests/hobbies and/or activities you engage in (e.g., clubs, organizations, etc.): ___________

____

____

Daily Routines

Check any problems with independent skills of daily living:

Skill	Yes	No	Comments
Eating			
Mobility			
Toileting			
Grooming			
Dressing			
Medication			
Meal Preparation			
Shopping			
Housework			
Laundry			
Finances			
Home Repair/Yard Work			
Driving			
Other:			

Thank you for taking the time to complete this form completely. The information that you have given us will help us provide efficient and effective speech-language services.