SPEECH AND HEARING CENTER Phone: 251-445-9378
University of South Alabama FAX: 251-445-9377
Department of Speech Pathology and Audiology
5721 USA Drive North Room 1119, Mobile, Alabama 36688-0002

ADULT CASE HISTORY FORM

Date_____

Speech-Language Pathology

Patient's Name_____ Date of Birth_____ Male___ Female___
Address_____
Street City State Zip

Telephones: Home_____ Cell_____ Work_____
Email_____Occupation_____
Highest Grade Completed_____ Marital Status_____ Spouse's Name_____

Persons living in the Home:

Name	Age	Sex	Grade Completed	Employer

Primary Care Physician_____ Phone_____
Referred by_____ Phone_____
Address_____
Street city state zip

Briefly describe the communication problem_____
_____

Check any condition(s) that apply or describe why you were referred:

- ☐ Stuttering/Stammering
- ☐ Hoarse or weak voice
- ☐ Other voice problem
- ☐ Laryngectomy
- ☐ Communication problems from stroke
- ☐ Communication problem from head injury
- ☐ Dialect/pronunciation problems
- ☐ Swallowing problems
- ☐ Mental retardation
- ☐ Dementia/Cognitive problems
- ☐ Hearing loss
- ☐ Cochlear implant

Other _____

1. What do you feel is the cause of your speech/language or hearing problem?
   _____
2. Did you have any speech/language or hearing problems in childhood?_____ If yes, please describe_____

3. Does anyone in your family have the same or other communication problem? _____ If yes, describe_____
4. What previous testing and/or treatment have you had for this problem?
   _____
5. How often/under what circumstances are you required to talk?
   _____
6. Do you wear hearing aids? _____ Dentures? _____ Eyeglasses? _____

Employment experience (begin with present employment):

Employer	Title/Job Description
_____	_____
_____	_____
_____	_____

Check any illness or conditions that apply to you:

☐ High blood pressure	☐ Drug abuse	☐ Asthma
☐ High cholesterol	☐ Ear infections	☐ Vision problems
☐ Diabetes	☐ Heart problems	☐ Hearing problems
☐ Smoking	☐ Stroke	☐ Learning problems
☐ Alcohol use	☐ Head injury	☐ Mental health problems

List any surgeries/accidents/injuries:

Problem	Date
_____	_____
_____	_____
_____	_____

List all medications taken regularly: _____
_____

Do you have any physical limitations, such as paralysis? _____
_____

Additional Comments: _____
_____
_____
_____

PLEASE ASK YOUR PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL TO FAX ANY PERTINENT MEDICAL RECORDS TO THIS CLINIC PRIOR TO YOUR APPOINTMENT. FAX#:251-445-9377 ATTN: CLINIC SECRETARY

_____
Signature of person completing form