THE UNIVERSITY of NORTH CAROLINA
GREENSBORO
School of Health
and Human Sciences

UNCG Speech and Hearing Center
Department of Communication Sciences & Disorders

ADULT SPEECH-LANGUAGE CASE HISTORY

All information provided on this form will be held in the strictest confidence in accordance with HIPAA regulations.

I. General Information

Today's Date: _____
Name: _____ Date of Birth: _____ Gender: _____
Address: _____
Preferred phone # to call: _____ Alternate _____
Person completing this form: _____ Relationship to client: _____
Language(s) spoken in the home: _____

II. Reason For Referral

Are you interested in (1) an evaluation___ (2) treatment ____ (3) evaluation & treatment_____
What are your concerns regarding your speech or language? _____
_____
_____
_____
What question(s) would you like answered as a result of an evaluation here?
_____
_____
_____
Does your communication difficulty arise from an injury or illness? ____ yes ____ no If yes, please describe:_____
_____
_____

III. Background Information

Education- *Mark the highest grade attended*: 1 2 3 4 5 7 8 9 10 11 12 *College*: 1 2 3 4
Education beyond college? _____
Current Occupation: _____Employer_____
Marital Status: ____Married ____Widowed ____Separated ____Divorced ___Single

IV. Health History

Check any medical condition(s) that may or may not be related to your communication.

_____Vocal nodules	_____ Aneurysm	_____Stroke (right)	____Alzheimer's Disease
_____ Laryngectomy	_____ Thrombosis	_____Stroke (left)	____Parkinson's Disease
_____ Loss of Voice	_____ Heart disease	____Traumatic Brain Injury	____Learning Disability
_____ Seizures	_____ Diabetes	____ Hearing Impairment	____ Deafness

Other _____
Describe your current health status/problems: _____
_____
_____
_____

Are you currently being followed by a physician for an injury or illness described above? _____ If so, please state the reason: _____
_____
_____
List any medication(s) you are currently taking: _____
_____ _____ _____
Describe any physical limitations: _____
_____
Do you currently wear hearing aids? _____

V. Evaluations and Treatment

If you have you seen other professionals concerning your communication, please enter the information below. You may include physicians, speech-language pathologists, audiologists, physical therapists, occupational therapists, psychologists and tutors, etc.

Name: _____ Title:_____
Reason: ____ Treatment ___ Evaluation Date(s) of Service: _____

Name: _____ Title:_____
Reason: ____ Treatment ___ Evaluation Date(s) of Service: _____

Name: _____ Title:_____
Reason: ____ Treatment ___ Evaluation Date(s) of Service: _____

Please provide us with copies of current reports from any of the above listed individuals/agencies whom you deem appropriate in order to best prepare for treatment or evaluation.

III. Additional Information

Please write any additional information you think will help us in addressing your concerns.