BAYLOR UNIVERSITY
COMMUNICATION SCIENCES AND DISORDERS

Baylor Speech-Language & Hearing Clinic
Speech-Language Case History
ADULT

Date: _____

Alert:

Identifying Information
Name: _____
Age: _____ DOB: _____ Sex: Male Female
Home Street Address: _____ City: _____
State: _____ Zip code:_____
Home phone: _____ Work phone:_____ Cell phone: _____
Occupation: _____ Email: _____
Person completing this form: _____ Relationship to client:_____
Alternate Contact:
Name: _____ Phone: _____
Address: _____

Primary Language _____ **Secondary Language** _____
Have you been seen at this facility previously? _____ **Date/s:** _____

Do you currently have hearing problems? Y N If yes, what is being done? _____
_____
Do you currently have vision difficulties? Y N If yes, what is being done? _____
_____

Statement of Problem/ Referral:
Diagnosis/Date of Diagnosis:_____
Describe as completely as possible the speech, language, and hearing problem. _____
_____
_____
Referral Source: _____
When was the problem first noticed? _____
_____
How has the problem changed since you first noticed it? _____
_____
What do you hope to learn from this evaluation and what do you think should be done?
_____
_____
Tell the reaction of you and other family members to the problem_____
_____
Family history of speech/language problems _____

This information is strictly confidential and cannot be provided to individuals or agencies without written consent.

Do you stutter: never _____ rarely _____ occasionally _____ frequently _____
If yes, then how long has this been a problem? _____
Do you have an unusual voice quality? (loud, soft, hoarse, nasal) _____
In what country have you lived most of your life?_____
What other languages do you speak, understand, read, or write? _____
Give other information to explain your communication problem _____
_____

Do you use an Augmentative Communication Device/System? Yes No If so what?_____

Please give information below about any of the following services you have received.

Services	**Date or dates**	**Person/ agency**	**Findings**
Speech/language Evaluation			
Speech/language Therapy			
Hearing evaluation			
Psychological testing/ Counseling			
Vocational counseling			
Physical therapy			
Occupational therapy			

Family
Others living in the home:

Name	Age	Relationship	Diagnosed Speech/Learning Problem

Explain current significant family stressors _____
Previous family stressors _____
Please list the name and ages of your children. _____
_____

This information is important for diagnosis and treatment. Please answer carefully.
Histories
Client's Prenatal and Birth History
Full term _____ Normal Birth _____
Explain any complication related to prenatal events/delivery_____
_____
Client's Child Development
Your general impression of your overall development:
slow _____ normal_____ advanced_____

Client's Early Motor development
slow _____ normal ____ advanced ____

Medical History

Allergies:
List all food allergies:

_____

_____

_____

Are you allergic to latex? Yes No Not Known

Illnesses/Conditions
Check those that apply and fill in approximate date/s:

Allergies (seasonal)		Long term memory problems	
Amputations		Short term memory problems	
Asthma		Meniere's disease	
Attention Deficit Disorder		Mental Retardation	
Autism		Neuromuscular Disease	
Behavior problems		Amyotrophic Lateral Scelrosis	
Braces		Epilepsy	
Cancer: type_____		Multiple Sclerosis (MS)	
Cerebral palsy		Muscular Dystrophy (MD)	
Cleft palate/submucous cleft		Parkinson's disease	
Cochlear implant		Other: _____	
Concussion		Noise Exposure	
Coma		Physical Abnormalities	
CVA/ stroke		Pneumonia	
Aphasia		Poor appetite	
Apraxia		Schizophrenia	
Dysarthria		Seizures/convulsions	
Dentures upper lower		Sensory Integration Disorder	
Diabetes		Serious injury _____	
Digestive problems		Stuttering	
Drooling		Surgery: _____	
Dyslexia		Swallowing problems/dysphagia	
Ear infections		Syndrome (other): _____	
Emotional problems		Tinnitus	
Encephalitis/Meningitis		Traumatic Brain Injury (TBI)	
Falls frequently/balance		Auto accident	
Hand preference R L		Post Concussive Syndrome	
Hearing aids- which ear R L		Other_____	
Hearing amplification device		Vocal fold pathologies	
Intubation: length of time _____		Hoarseness	
Lengthy medication treatment		Laryngectomy	
Memory Problems		Polyps/ Nodules	
Confusion		Speaking valve	

Recent hospitalization/what for/dates:_____

_____

_____

Are you currently under a doctor's care? If yes, what reason?_____

_____

What current medication(s) are you taking? _____

_____

Do you have any eating or swallowing difficulties/PEG tube? If yes, describe. _____

_____

Have you had a modified barium swallow study or Fiberoptic Endoscopic Evaluation? If yes, when and by whom? (dates)_____

_____

Are you on a special diet or diabetic diet? (thickened liquids, pureed foods, etc.)_____
_____
Describe any major surgeries, operations, or hospitalizations (include dates). _____
_____
_____
Describe any major accidents. _____

Education University Graduate Work
Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 1 2 3 4
List any area of specialization, vocational training, or area of university study._____
_____
Describe any other education or special training. _____
_____
Do you have a history of learning difficulties? If yes, please explain. _____
_____

Employment History
Most recent occupation _____ How long? _____
Employer _____ Are you still employed? Yes ____ No _____
What are your current employment arrangements? _____
_____
Describe briefly the type of work you are/were doing in current/past occupations._____
_____

Please give any additional information that will help us in the evaluation: _____
_____

Primary physician
Name_____
Address _____
Phone Number_____
Diagnosis _____

Other professionals by whom you have been treated/evaluated
Name/Position_____
Address_____
Phone Number_____
Diagnosis _____

I wish reports to be sent to these persons/agencies:
Name _____
Title _____
Address _____
Phone _____

Name _____
Title _____
Address _____
Phone _____

_____ _____ _____
Signature of person completing this form Relationship to client Date

Baylor University Speech-Language & Hearing Clinic

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, _____ who resides at _____

In the city of _____ in the state of _____ hereby authorize:

Baylor University Speech-Language & Hearing Clinic
One Bear Place #97332
Waco, Texas 76798-7332

to disclose the following specific health information by □ mail or □ fax or □ email to:

Name: _____

Address: _____

City, St., Zip: _____

from the Health Records of:

Name: _____

(NAME OF INDIVIDUAL WHOSE RECORD IS BEING DISCLOSED)

Address: _____

City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Diagnostic Reports

_____ Hearing Reports

_____ Session Reports

_____ Test Results

_____ All of the above

_____ Other (must be specific) _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, expect as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.

4. Baylor University, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.

6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) DATE

_____ _____

PATIENT'S NAME PRINTED EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM ABOVE DATE)

_____ DATE

WITNESS

_____

Baylor University Speech-Language & Hearing Clinic

One Bear Place #97332
Waco, TX 76798-7332

Release of Information

Date: _____

RE: Name: _____ DOB: _____

To Whom It May Concern:

I hereby grant permission for _____ to disclose and deliver
(name of school/institution or above agencies)

any information requested by _____ concerning my
(name of school/institution)

son/daughter _____.

This information may include case history, results of examination, impressions, and recommendations

that might benefit _____ in treating
(name of school/institution)

_____ speech and communication disorder.

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.
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6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____
Signature

_____
Relationship

Consent Agreement

I understand that the Baylor University Speech and Hearing Clinic, hereafter referred to as the Center, is operated as a training center for speech-language pathologists and that all therapy conducted at the Center is supervised by a licensed clinician and that all lessons may be observed by students in training or by students who may be interested in majoring in this field.

I further understand that many of the lessons are recorded by television or on tape recorder and that these lessons may be played in speech therapy classes as examples of speech, language, and hearing disorders or may be presented at professional meetings of doctors, dentists, psychologists or speech clinicians or other professional groups and that these recordings may be analyzed and the information used for research reports. I also understand that testing information and treatment progress as recorded in the client file may be used for research purposes. I further understand that when such usages are made of this information or recordings, that the names of the patients treated will be concealed.

I agree and understand that Baylor may freely use these tapes and files for purposes of education and research.

I further agree and understand that by signing this Consent Agreement, these recordings and files become the property of the Center and I hereby relinquish any and all claims to benefits, financial or otherwise which I had, now have, or may have in the future or which my heirs, executors, administrators, or assigns may have or claim to have from the use of these recordings.

BY: _____

(Date)

BAYLOR
UNIVERSITY

Notice of Privacy Practices
Acknowledgement of Receipt

Today's Date: _____

I acknowledge that I was provided with a copy of the Baylor University Notice of Privacy Practices for Health Services and Clinics.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative (e.g., parent or legal guardian), please print and sign your name in the space below.

_____ _____
Personal Representative (Print) Personal Representative Signature

_____
Relationship

For Baylor University use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Other: _____

_____ _____
Employee Name Date

This form should be placed in the patient's record.

Baylor University
Health Services & Clinics

HIPAA Privacy Officer
Deborah L. Holland, JD, MPH, CHRC, CHPC
254-710-1438; HIPAA@Baylor.edu
http://www.baylor.edu/HIPAA/

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: August 1, 2017

This Notice of Privacy Practices applies to the following organizations.

Baylor University Health Services/Health Center (faculty, staff, non-student program attendees only)
Baylor Speech, Language, and Hearing Clinic
Baylor Psychology Clinic
Baylor Center for Developmental Disabilities

HIPAA Privacy Officer: Deborah L. Holland, JD, MPH, CHRC, CHPC
One Bear Place #97310
Waco, TX 76798-7310
254-710-1438; HIPAA@Baylor.edu
http://www.baylor.edu/HIPAA/