Baylor University
ROBBINS COLLEGE OF HEALTH AND HUMAN SCIENCES
Communication Sciences and Disorders

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

Date: _____

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 patient:_____
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:
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 has been done about it? Has this helped? _____
_____
What do you think caused the problem? _____
_____
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: none _____ 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 _____
_____

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 stresses _____
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 ____ Pre-Term ____ Number of weeks gestational _____ 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
Illnesses/Conditions
Check those that apply and fill in approximate date/s:

Allergies		Intubation: length of time _____	
Amputations		Lengthy medication treatment	
Asthma		Memory	

Attention Deficit Disorder		Confusion	
Augmentative communication device		Long term memory problems	
Behavior problems		Short term memory problems	
Braces		MR	
Brain injury		Neuromuscular Disease	
Cancer		Multiple Sclerosis (MS)	
Cerebral palsy		Muscular Dystrophy (MD)	
Cleft palate/submucous cleft		Parkinson's disease	
Cochlear implant		Other: _____	
Convulsions		Noise Exposure	
CVA/ stroke		Physical Abnormalities	
Aphasia		Pneumonia	
Apraxia		Poor appetite	
Dysarthria		Schizophrenia	
Dentures upper lower		Seizures	
Digestive problems		Serious injury:	
Drooling		Hospitalization for _____	
Dyslexia		Stroke/ CVA	
Ear infections		Stuttering	
Emotional problems		Swallowing problems	
Encephalitis/Meningitis		Syndrome (other): _____	
Falls frequently/balance		Traumatic Brain Injury (TBI)	
Glasses		Auto accidents	
Hand preference R L		Other: _____	
Head injury		Vision problems	
Hearing aids- which ear R L		Vocal fold pathologies	
Hearing amplification device		Hoarseness	
Hearing problems		Laryngectomy	
Meniere's disease		Polyps/ Nodules	
Tinnitus		Speaking valve	

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? If yes, describe. _____
_____

Have you had a swallow study completed? If yes, when and by whom? _____
_____

Are you on a special diet? (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) _____

_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS
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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)

_____

WITNESS

_____

DATE

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.
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_____
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)