WORCESTER STATE UNIVERSITY

Speech-Language-Hearing Center
486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 Fax: 508-929-8175

Date Received: _____
(Office Use Only)

SPEECH–LANGUAGE–HEARING CENTER

Adult Case History Form (Confidential)

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports from previous agencies with this case history form. Once we have received requested reports, an evaluation/treatment will be scheduled as soon as an opening becomes available.

Personal Information

Date:_____

Name:_____ Date of Birth:_____ Age:_____ Gender:_____

Address:_____
(# Street)

_____
City State Zip Code

☐ Home Phone:_____ ☐ Cell Phone:_____ ☐ Business Phone:_____
check preferred number to contact

Are you a Worcester State University **faculty / staff / student** ? ☐ Yes ☐ No If yes, circle one.

Name of person giving information, if different from above:_____

Relationship to client:_____

Referred by:_____

Reason for referral:_____

Have you been evaluated or treated at this clinic before? Yes ☐ No ☐

If yes, when:_____

For what reason:_____

Family Information

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Name of Spouse/Partner:_____

Children's names and ages:_____

_____

Other persons living in your home and their relationship to you:_____

_____

Educational/Occupational/Social Information

Highest level of education completed:_____

Occupation:_____

Current Employer:_____

What do you do in your spare time?_____

Medical Information

General health is: Good ☐ Fair ☐ Poor ☐

Please indicate whether or not you have had any of the following illnesses or conditions:
(For any "yes" responses, please explain below)

Accidents	Yes ☐	No ☐	Heart Problem	Yes ☐	No ☐
Adenoidectomy	Yes ☐	No ☐	High Fever	Yes ☐	No ☐
Allergies	Yes ☐	No ☐	Meningitis	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐	Mental Illness	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Multiple Sclerosis	Yes ☐	No ☐
Behavior Difficulties	Yes ☐	No ☐	Neurological	Yes ☐	No ☐
Cancer/Tumor	Yes ☐	No ☐	Noise Exposure	Yes ☐	No ☐
Concussion	Yes ☐	No ☐	Otosclerosis	Yes ☐	No ☐
Dementia	Yes ☐	No ☐	Paralysis	Yes ☐	No ☐
Depression	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Sinusitis	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Ear Infections	Yes ☐	No ☐	Surgery	Yes ☐	No ☐
Encephalitis	Yes ☐	No ☐	Thyroid Problem	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Tonsillectomy	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Tonsillitis	Yes ☐	No ☐
Head Injury	Yes ☐	No ☐	Voice Problems	Yes ☐	No ☐
			Other	Yes ☐	No ☐

If you answered yes to any of the above items, please explain in detail:_____

_____

Please describe any other medical conditions you may have that are not listed above:_____

_____

Current Medications: (prescribed, over-the-counter, herbal)_____

_____

Primary Care Physician's Name:_____

Address:_____Phone Number:_____

Other Health Care Providers (please list name, specialty and phone number):_____

_____

Speech and Language History

What is the predominant language spoken in the home?_____

What other language(s) do you speak? In what settings (e.g., church, work, social settings)?_____

_____

What language(s) do you read and write?_____

Describe your communication problem:_____

_____

_____

_____

Why are you concerned about your communication?_____

_____

What do you think caused your communication difficulty?_____

_____

_____

How long have you had this difficulty?_____

Are there any other family members with communication difficulties? Yes ☐ No ☐

If so, list relationship and explain difficulty:_____

_____

_____

Have you ever attended speech-language-hearing therapy? Yes ☐ No ☐

If so, when? _____

Agency/Speech-language pathologist's name and address _____

_____

How do you communicate with others? Please check all that apply.

Speech ☐ Gestures ☐ Communication Book ☐ Writing ☐ Sign Language ☐

Voice Output System (Mini-Mercury, Dynamite, etc.)_____

Do you have any difficulty with swallowing? Yes ☐ No ☐

If so, please explain and list your current diet:_____

_____

Do you use any of the following assistance devices?

Wheelchair ☐ Walker ☐ Cane ☐ Glasses ☐ Other _____

Auditory History

Do you have a hearing problem? Yes ☐ No ☐ In which ear? Right ☐ Left ☐ Both ☐

When was the onset of your hearing problem? _____ Was the onset: Sudden ☐ Gradual ☐

Does your hearing fluctuate from day to day? Yes ☐ No ☐

What was the cause of your hearing loss?_____

_____

Do you experience any sounds (tinnitus) in your ears or your head? Yes ☐ No ☐

Do you ever experience dizziness, balance problems or spinning sensations? Yes ☐ No ☐

If yes, please describe fully:_____

_____

Do you wear a hearing aid? Yes ☐ No ☐

Audiologist's name and address (if applicable): _____

Otolaryngologist's (ENT) name and address (if applicable): _____

Summary

Provide additional information that you believe might be helpful in the evaluation or remediation process. Attach additional pages if needed. _____

_____

Signed:_____ Date:_____

How did you hear about our services?

☐ Radio
☐ Mailing
☐ Alumni
☐ Family/Friend
☐ Website
☐ WSU posting
☐ Senior Presentation
☐ Television
☐ Newspaper
☐ Health Fair
☐ Higher Education Consortium of Central Massachusetts (HECCMA)
☐ WSU Employee
☐ Other:_____

Reminder

Before returning this paperwork to Worcester State University Speech-Language-Hearing Center, have you:
Completed this case history in its entirety?
Read and signed the following release forms?
• Authorization for Observation and Audio/Video Recording ☐
• Authorization for Release of Information ☐
Contacted other agencies to have them forward reports to you or directly to the Worcester State University Speech-Language-Hearing Center?

For additional information, please contact:

Ann T. Veneziano-Korzec, M.S., CCC-SLP , Director • 508-929-8055

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_____ Diagnostic Evaluation
_____ Therapy

Date Received: _____
(Office Use Only)

WORCESTER STATE UNIVERSITY

Name: _____

SPEECH–LANGUAGE–HEARING CENTER
486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 • Fax: 508-929-8175

DOB: _____

Adult Fluency: Addendum to Adult Case History Form *(confidential)*

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports from previous agencies with this and the case history form. Once we have received requested reports, an evaluation/treatment will be scheduled as soon as an opening becomes available.

1. When was your stuttering first noticed? _____
   By whom? _____

2. What do you believe caused your stuttering? _____

3. Has your stuttering changed since it began? Yes ☐ No ☐
   If yes, please explain. _____
   _____
   _____

4. List situations in which your stuttering is worse. _____
   _____
   _____

5. List situations in which you hardly stutter. _____
   _____
   _____

6. Does your stuttering affect your ability to interact with others in school or at work? Yes ☐ No ☐
   If yes, please explain. _____
   _____

7. Does your stuttering affect your ability to interact with others socially? Yes ☐ No ☐
   If yes, please explain. _____
   _____

8. Have you ever avoided speaking because of your stuttering? Yes ☐ No ☐
   If yes, please explain. _____

9. Do you use a fluency facilitative device, such as the Speech Easy or Fluency Master?

Yes ☐ No ☐

If yes, please explain: _____

_____

10. Is there anything you do that helps you when you stutter? Yes ☐ No ☐

If yes, please explain. _____

_____

11. Why are you seeking therapy at this time? _____

_____

_____

Please answer questions 12 and 13 only if you have had previous therapy.

12. What have you found most helpful in your previous therapy experiences? _____

_____

_____

13. What have you found least helpful in your previous therapy experiences? _____

_____

_____

14. What are you hoping will happen as a result of therapy? _____

_____

_____

15. Please describe any other concerns that you have at this time. _____

_____

_____

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Authorization for Observation and Audio/Video Recording

I, _____, consent to the following that I have checked below
(person completing form)

for_____ (please check all that apply)
(Client's Name)

_____I consent and authorize the taking of photographs, audio and/or video recording as well as closed circuit televised monitoring of the client specified above (e.g., client and persons associated with the client), by the Worcester State University Speech-Language-Hearing Center (WSU-SLHC). I understand that the WSU-SLHC is an educational facility and therefore consent that the visual and audio displays as described above may be used for educational training or treatment purposes including (please initial all for which you give consent):

___ (1) Case managers, undergraduate and graduate students associated with the Worcester State University Communication Sciences & Disorders Department;
___ (2) Other professionals, such as speech-language pathologists, audiologists, educators, and administrators,
___ (3) Published or professional journals;*
___ (4) Professional or educational conferences.*

* Names of participants in the recording will not be disclosed

_____I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow qualified professional personnel and students connected with the WSU Department of Communication Sciences & Disorders and SLHC to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors or by closed circuit television for professional purposes.

_____I consent and authorize the person (s) listed below to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors.

_____ _____
_____ _____

_____ _____ _____
Client or Parent/Legal Guardian Date Case Manager

Revised/Fall 2016

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Speech–Language–Hearing Center
Phone: 508-929-8055
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Authorization for Release of Information

Client's Name _____ Date of Birth _____

Client's Address _____

_____

I HEREBY AUTHORIZE WORCESTER STATE UNIVERSITY SPEECH-LANGUAGE-HEARING CENTER TO:

OBTAIN FROM: Name of Facility _____

Individual _____

Address and Street No. _____

City/Town _____ State _____ Zip _____

Phone _____

I HEREBY AUTHORIZE WORCESTER STATE UNIVERSITY SPEECH-LANGUAGE-HEARING CENTER TO:

FURNISH TO: Name of Facility _____

Individual _____

Address and Street No. _____

City/Town _____ State _____ Zip _____

Phone _____

The following information concerning the above client pertaining to services provided on or about

Date _____

Information Requested _____

_____

Restrictions (if any) _____

_____ _____
Date Signature of Client

_____ _____
Date Signature of Parent or Guardian

_____
Relationship to Client