



SPEECH-LANGUAGE-HEARING CENTER

Audiology – 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.

Personal Information

Date: _____

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

Address: _____
(# Street)

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Are you a Worcester State University **faculty** / **staff** / **student** ? 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 Center before? Yes No

If yes, when and for what reason? _____

History

Reason for visit (primary complaint): _____

Have you ever had your hearing evaluated before? No Yes

When and why? _____

Do you have concerns about your hearing? No Yes

In which ear? Right Left Both

When was the onset of your hearing loss? _____

Was the onset sudden? No Yes gradual? No Yes

Does your hearing fluctuate from day to day? No Yes

What was the cause of your hearing loss? _____

Please check any of the following that are true of your hearing now:

- I can hear, but I do not have a clear understanding of what I am hearing.
- I have difficulty hearing in one-on-one situations in a quiet environment.
- I have difficulty hearing in groups.
- I have difficulty hearing with background noise.
- I prefer to have the television turned louder than those around me.
- I have difficulty hearing on the telephone.

Do you presently use a hearing aid? No Yes

If yes, for how long? _____

Have you ever been to an otolaryngologist (Ear, Nose, and Throat physician)?

No Yes : When and why? _____

Does anyone in your family have a hearing loss? No Yes : Who? _____

Have you ever been exposed to loud sounds (gunfire, heavy machinery, loud music, etc.)? No Yes

Please explain. _____

Please indicate if you have / had any of the following:

- Noise in your ears or head Pain in your ears
- Fullness or stuffiness in your ears Facial numbness or tingling
- Drainage or discharge from ears

Do you ever feel dizzy, unsteady, or off-balance? No Yes

If yes, is your dizziness accompanied by:

Nausea	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Vomiting	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Noise in ears	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Do you have concerns about speech and/or language issues? No Yes

Please explain. _____

How would you rate your general health? Poor Fair Good Excellent

Are you currently on any medication? No Yes

If yes, please list: _____

Please indicate if you have ever had any of the following:

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear aches/infections | <input type="checkbox"/> High fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting | <input type="checkbox"/> Measles | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent laryngitis | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent upper respiratory infections | <input type="checkbox"/> Otosclerosis | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dizziness | | <input type="checkbox"/> Scarlet fever | _____ |

Please indicate if you have ever taken any of the following medications:

- Mycin Antibiotics (e.g. Streptomycin, Kanamycin, Neomycin, Gentamycin, Tobramycin, Amikacin, Erythromycin, Vancomycin)?
- Aspirin (or Aspirin containing products) at least 6-8 per day for extended periods of time?
- Non-steroidal anti-inflammatory drugs (Advil, Aleve, Indocin, Motrin, Naprosyn, Nuprin) at least 6-8 per day for extended periods of time?
- Quinine or quinine containing products (e.g., Malaria medicine, muscle cramps, excessive intake of tonic water)?
- Intravenous Diuretics?
- Chemotherapy?

If you checked any of the above medications, please elaborate: _____

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?

- | | |
|--|--|
| <input type="checkbox"/> Radio | <input type="checkbox"/> Television |
| <input type="checkbox"/> Mailing | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Alumni | <input type="checkbox"/> Health Fair |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Higher Education Consortium of Central Massachusetts (HECCMA) |
| <input type="checkbox"/> Website | <input type="checkbox"/> WSU Employee |
| <input type="checkbox"/> WSU posting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Senior Presentation | |

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/DVD 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



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



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

Date

Signature of Client

Signature of Parent or Guardian

Relationship to Client