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 send it and additional relevant reports (speech-language, hearing, neurology, psychology) from other agencies to the address above. This information will help us to plan your evaluation and/or treatment.

Date:______________

Name:______________________________________ Legal name, if different:______________________________

Date of Birth:_____________ Age:________ Gender:______________ Pronouns:________________________

Race/Ethnicity (Check all that apply): ☐ Prefer not to answer ☐ American Indian/Alaskan Native ☐ Asian
☐ Black/African American ☐ Latino/Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White

Are you a Worcester State University **faculty / staff / student / none of these** ? Circle one.

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

Relationship to client:____

Are you your own legal guardian? Yes ☐ No ☐ If no, please provide the name of your legal guardian here and include accompanying documentation with this form:

____

Referred by:____

Reason for referral:____

Have you been evaluated or treated at this Center before? Yes ☐ No ☐
If yes, when and for what reason?____

Contact Information

Address:____
(# Street)

____
City State Zip Code

Home Phone:_________________ Cell Phone:_____________________ Business Phone:_________________

Rev 2/2023

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:

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

____

Have you fallen in the last year? Yes ☐ No ☐

Have you fallen two or more times in the last year? Yes ☐ No ☐

Are you afraid to fall because of your balance? Yes ☐ No ☐

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 ____________________________

____

What did you work on? ____________________________

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 to Obtain, Release and Discuss Client 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 the Center at 508-929-8055

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_______ Diagnostic Evaluation

_______ Therapy

Rev 2/2023

Date Received: ____________
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WORCESTER STATE UNIVERSITY

Name: ______________________________

SPEECH–LANGUAGE–HEARING CENTER
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DOB: ____________________

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

Please complete this form and send it and additional relevant reports (speech-language, hearing, neurology, psychology) from other agencies to the address above. This information will help us to plan your evaluation and/or treatment.

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 to Obtain, Release, and Discuss Client Information

Client's name ____
Print first name middle initial last name

Client's date of birth ____________________

Check all that you authorize:

☐ Get information from ☐ Send information to ☐ Discuss information with

____
Print first and last name of person

____
Print name of facility

____
Print street address

____
Print City, State, and Zip Code

_______________________________ _______________________________
Phone number Fax number

Please check
☐ I agree to have a graduate student clinician under the supervision of a clinical instructor, and / or the clinical instructor, obtain/release/discuss (see above) the following information from/to/with the above listed person/facility.

☐ I agree to have the audiologist obtain/release/discuss (see above) the following information from/to/with the above listed person/facility.

____

____

____

Authorization: ____
Signature of client or guardian relationship to client

Date: ____

Clinical instructor reviewed: ____

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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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Consent for Access to Records

I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow faculty and clinical instructors connected with the WSU Department of Communication Sciences and Disorders to access and use my records/_________________'s records (without the use of identifying
Client name

information) for research and/or academic purposes at WSU.

______________________________ _________________
Signature Date

____
Print name

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Client Consent for Research

Client Name: ____

The Speech-Language-Hearing Center serves as a training site for students in the Communication Sciences and Disorders Department at Worcester State University. As a research and teaching institution, we are asking your permission to use de-identified (your personal information has been removed) information for teaching and research purposes. An example of a teaching activity might be using de-identified test information to instruct students on how to administer a test and interpret scores. An example of a research activity might be, with permission from our Institutional Review Board, using de-identified information in presentations or in research papers.

I consent to allow members of the Communication Sciences and Disorders Department at Worcester State University to use de-identified information for:

- teaching purposes:
  - ☐ YES
  - ☐ NO
- research purposes:
  - ☐ YES
  - ☐ NO

I consent to be contacted regarding participation in a research study:

- ☐ YES
- ☐ NO

____

Client or Parent/Legal Guardian

____

Date

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