Saint Xavier UNIVERSITY
Ludden Speech and Language Clinic

ADULT CASE HISTORY FORM

Any client applying for services at the Ludden Speech and Language Clinic is required to answer all questions as completely and accurately as possible.

If you have any other information from other professionals, such as medical records or school evaluations, please forward copies of those documents along with this case history form.

**Please note this is not a peanut-free facility.

The Ludden Speech and Language Clinic maintains confidentiality of all client records, including any documentation which you provide from other facilities.

GENERAL INFORMATION: (Print)

Client's Legal Name: _____ Date: _____

Client's Preferred Name (if different): _____

Client Preferred Pronouns: _____

Date of Birth: _____ Age: _____

Address: _____
(Street) City/State ZIP Code

Home Phone: _____ Cell Phone: _____

Email: _____

Language (Please check one): ❑ Monolingual ❑ Bilingual ❑ Multilingual Caregiver(s)

Languages Spoken: _____

Check all that apply:
❑currently employed ❑part time ❑full time ❑retired ❑disabled ❑student

Current Occupation: _____

Previous Occupation: _____

REFERRAL INFORMATION & DESCRIPTION OF THE PROBLEM

Who referred you to this clinic? (List name): _____

Profession of Person or Relationship to You: _____

Reason for Referral (Please check yes or no):

Reading: ❑Yes ❑No

Writing: ❑Yes ❑No

Speaking: ❑Yes ❑No

Listening: ❑Yes ❑No

Cognition: ❑Yes ❑No

Voice: ❑Yes ❑No

Other: ❑Yes ❑No

Please provide more information on any items checked "yes" above:

When did your communication problem first begin?

What are your goals for your communication? What would you like to be able to do better?

EDUCATIONAL HISTORY

Name of Last School Attended: _____

Number of Years You Attended School: _____Highest Degree Earned: _____

FAMILY HISTORY

Your current marital status: ❑ married ❑ single ❑ widowed ❑ other_____

Number of children you have: _____ What are their ages? _____

List the Names of Those Living with You	**Relationship to You (partner(s), child, friend, etc.)**
Name: _____	_____
Name: _____	_____
Name: _____	_____
Name: _____	_____

Do you have a developmental disability, syndrome or learning disability? ❑ No ❑ Yes (Describe)

Does anyone in your family have a developmental disability, syndrome, learning disability, or history of speech, language or hearing difficulties? ❑ No ❑ Yes (Describe)

MEDICAL HISTORY

Please check the "Yes" or "No" box to indicate whether you have/had any of the following:

Yes	No		Yes	No	
❑	❑	Diabetes	❑	❑	Frequent Colds
❑	❑	High Blood Pressure	❑	❑	Laryngitis/hoarseness
❑	❑	Thyroid Problems	❑	❑	Dental Problems
❑	❑	Heart Attack	❑	❑	Attention Deficit Disorder
❑	❑	Other Heart Disease	❑	❑	Mental Illness
❑	❑	Respiratory Problems (asthma, emphysema, other)	❑	❑	Schizophrenia
			❑	❑	Bipolar
❑	❑	Gastrointestinal (digestive problems)	❑	❑	Depression
			❑	❑	Fatigue
❑	❑	Reflux (GERD)	❑	❑	Stress
❑	❑	Allergies	❑	❑	Anxiety Disorder
❑	❑	Kidney Problems	❑	❑	Obsessive Compulsive
❑	❑	Arthritis	❑	❑	Asperger's/Social Language
❑	❑	Lupus	❑	❑	Congenital Disorder (List):
❑	❑	Stroke	❑	❑	Dyslexia
❑	❑	Traumatic Brain Injury (including concussion)	❑	❑	Viruses (HIV, Herpes, Hepatitis)
❑	❑	Epilepsy/Seizures	❑	❑	Stuttering
❑	❑	Parkinson's Disease	❑	❑	Hearing Problems
❑	❑	Tremors	❑	❑	Surgeries
❑	❑	Headaches	(list) _____		
❑	❑	Meningitis	❑	❑	Other Medical Diagnoses
❑	❑	Other Neurological Disorders	(list) _____		
❑	❑	Bleeding Disorders	(list) _____		
❑	❑	Cancer (List part of the body affected):_____			
❑	❑	Swallowing Difficulty (if yes, please describe the difficulty that you have/had swallowing)			

If you answered yes to any of the above, please explain and comment below.

Describe any special techniques, equipment, and compensations you use.

If you are seeking services for voice, how much do you use your voice daily? Please check all that apply:

- ❑ Typical daily convesation
- ❑ Cheering at concerts/sports
- ❑ Speaking over noise
- ❑ High phone use or conference calls
- ❑ Prolonged voice use (4+ hrs/ day)
- ❑ Leading meetings/trainings
- ❑ Public speaking
- ❑ Teaching/lecturing
- ❑ Calling out to people or pets
- ❑ Singing or acting
- ❑ Talkative
- ❑ Other _____

Do you have any known allergies? ❑ Yes ❑ No
(If yes, please list below)

List all medications taken on a regular basis:

List all previous hospitalizations, reason and dates (add a piece of paper if needed)

Have you ever been seen by any of the following specialists? Check all that apply:

- ❑ Neurologist
- ❑ Behavior Specialist
- ❑ Orthodontist
- ❑ Psychiatrist
- ❑ Physical Therapist
- ❑ Dietitian
- ❑ Audiologist
- ❑ Occupational Therapist
- ❑ Psychologist
- ❑ Ear Nose Throat Physician
- ❑ Other _____

Please list names/approximate dates/and reasons for all specialists you have seen in the past (add a piece of paper if needed)

COMMUNICATION HISTORY AND CURRENT STATUS

Please check all statements that apply to your communication disorder and elaborate:

- ❑ My communication problem interferes with my social activities.
- ❑ My communication problem interferes with my performance at work.
- ❑ My communication problem interferes with my home life.
- ❑ My voice does not reflect the "true me."
- ❑ My voice difficulties restrict my social life.
- ❑ I feel anxious when I know I have to use my voice or communicate.
- ❑ I have difficulty recalling the names of common objects, people or places.
- ❑ My communication is not easily understood by people I know.
- ❑ My communication is not easily understood by strangers.
- ❑ I frequently say the wrong sounds in words.
- ❑ I am concerned about how well people understand or perceive my voice or speech.
- ❑ My speech contains many word repetitions or prolonged sounds.
- ❑ I often run out of breath while talking.
- ❑ It takes a great amount of effort to talk; I have to concentrate to make my voice sound the way I want or communicate the way I want.
- ❑ I have difficulty reading.
- ❑ I have difficulty learning and remembering new information.
- ❑ I have difficulty remembering things that I need to do, such as appointments or tasks for work.
- ❑ I have difficulty paying attention while having a conversation or completing a task.
- ❑ I have difficulty thinking through problems to find solutions.

Have you ever been seen by a Speech/Language Pathologist (SLP)? ❑Yes ❑No

If yes, please provide reports.

Do you have a hearing loss? ❑ No ❑Yes

Do you wear a hearing aid? ❑ No ❑ Yes

Do you have any vision problems? ❑ No ❑ Yes

Do you wear eyeglasses or contacts? ❑ No ❑ Yes

What are your interests and activities that you enjoy?

Overall, I would rate my communication as:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any other comments that may be helpful to us in planning your evaluation?

Please include any additional reports or information that might be helpful in the evaluation and/or remediation of your child's speech/language problem.

Person Completing Form: _____

Relationship to Client: _____

Signature of Legal Guardian (if applicable)_____ Date: _____

Signature of Client _____ Date: _____

Form Updated 3-06-23