Department of Communication Sciences and Disorders
James L. & Dorothy H. Dewar College of Education & Human Services
Speech-Language Hearing Clinic
Address 1500 N. Patterson Street • Valdosta, GA 31698-0104
Phone 229.219-1301 • **Fax** 229-219-1302 **Web** http://www.valdosta.edu/coe/comd
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PLEASE RETURN COMPLETED FORMS AS SOON AS POSSIBLE. YOU WILL BE CONTACTED FOR AN APPOINTMENT ONCE FORMS ARE RECEIVED.

CASE HISTORY-ADULT

Request appointment for evaluation of: **(Circle One)** **Speech/Language** **Hearing**

NOTE: A HEARING SCREENING IS INCLUDED IN A SPEECH/LANGUAGE EVALUATION.

Date:_____ Referred by:_____

Name of person completing this form and relationship to patient:_____

Identification

Name:_____

Date of Birth:_____Age:_____

Race/Ethnicity (for statistical purposes only): _____

Address:_____
(street/route)

_____
(City) (State) (Zip)

Place of Employment:_____Occupation:_____

Home Phone:_____Work Phone:_____Education:_____

Marital Status:_____ Name(s) of Spouse & Children:_____

Emergency Contact/Name: _____ Ph# _____

Name and Address of Physician:_____

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SPEECH, VOICE, AND HEARING HISTORY

Primary language spoken:_____

Describe the problem, concern, and/or difficult communication situations:

_____

_____

Possible cause(s) of problem:_____

Describe any treatment received:_____

Current Medications: _____

_____

For what conditions?_____

_____

Describe medical history including illnesses, surgeries, injuries:_____

_____

_____

Any speech, language, learning or hearing problems in your family? If yes, please describe:_____

Check any that apply and indicate age(s) condition occurred:

Ear Infections:_____Allergies_____High Fever_____

Dizziness_____Hearing Loss_____Tinnitus_____

Noise Exposure_____Seizures_____Stroke_____

Meningitis_____Swallowing Problems_____Other_____

Have you or do you currently use hearing aids or amplification? If yes, please describe

type and benefit: _____

Please give any additional information that might be helpful:_____

_____

_____

I understand that the VSU Speech and Hearing Clinic is a training facility for student clinicians in the Communication Sciences and Disorders program. I understand that student clinicians under the supervision of licensed professional(s) may render services. I authorize the VSU Speech and Hearing Clinic to provide services to me.

_____ _____

Signature of client or legal guardian **Date**

Revised 7/13