

**MILLER SPEECH AND HEARING CLINIC
TEXAS CHRISTIAN UNIVERSITY**

Mailing Address:
TCU Box 297450
Fort Worth, TX 76129

Street Address:
3305 W. Cantey
Fort Worth, TX 76129

CASE HISTORY (ADULT)

Date form completed: _____

Contact Information

Patient Name: _____ **Birthdate:** _____
Address: _____ **Home Phone:** _____
_____ **Cell Phone:** _____
_____ **Work Phone:** _____

Contact Person: _____ **Relationship to Patient:** _____

Address: _____ **Home Phone:** _____
_____ **Cell Phone:** _____
_____ **Work Phone:** _____

Primary Care Physician: _____ **Office Phone:** _____

Address: _____

Medical History and Referral

Referred by: _____

Reason for referral: _____

Diagnosis: _____

Date of onset: _____

Where were you hospitalized? _____

How long were you in the hospital? From _____ to _____

Did you receive speech-language therapy? ____ Yes ____ No

If yes, please provide the following information:

How long were you in therapy? From _____ to _____

How often were you seen for therapy? _____

What were the goals of therapy? _____

Other medical conditions: _____

Current medications: _____

Social History

Who do you live with? _____

What is your profession? _____

Are you currently working? ____ Yes ____ No

Do you plan to return to work? ____ Yes ____ No

What is your highest level of education? _____

What are your hobbies and interests? _____

Is a language other than English spoken or heard by you in the home?

_____ Yes _____ No

If yes, please provide the following information:

List the language(s) you speak (or spoke prior to the injury):

How old were you when you learned each language? _____

How often did you speak each language prior to the injury? _____

How often do you speak each language now? _____

How well did you speak each language prior to the injury? _____

Do you want to improve your ability to communicate in this language?

_____ Yes _____ No

List the language(s) the patient hears: _____

Communication Skills

	Yes	No
Do you have difficulty speaking?		
Do you have difficulty understanding what other people say?		
Do you have difficulty reading?		
Do you have difficulty writing?		

Please describe your current communication difficulties: _____

Please describe how your communication difficulties have affected your daily life (work, relationships, hobbies....): _____

Please describe how you communicate (words, gestures, writing...): _____

Please describe what you would like to improve about your communication:

Cognitive Skills

	Yes	No
Do you have difficulty with your memory?		
Do you have difficulty paying attention?		
Do you have difficulty with problem solving and reasoning?		

Please describe your cognitive difficulties: _____

Motor and Sensory Skills

	Yes	No
Do you have weakness or paralysis on one side of your body? If yes, circle: Right or Left		
Do you use a cane, walker or wheelchair?		
Do you have any vision problems? If yes, circle: glasses, contacts, or other		
Do you have a history of hearing loss?		
Do you wear a hearing aid?		
Do you have trouble swallowing?		
Are you on a special or modified diet?		

Additional Concerns

Do you have any additional concerns not addressed in this form? If yes, please describe them. _____
