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: _____

_____ Email:_____

Contact Person: _____

Relationship to patient: _____

Address: _____

_____

_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email: _____

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: _____

_____

Do you have a pacemaker? ____Yes _____ No

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

Circle one: are you right or left handed?

Is your ability to write impaired? If so, please describe._____

_____

What is your highest level of education? _____

_____

What are your hobbies and interests? _____

_____

_____

Are you currently using any type of device to aid your communication?

___iPad ____ android tablet ____ dynavox ___ other

If so, how do you use it? _____

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. _____

_____

Background Information (Optional)

To ensure that the Miller Speech and Hearing Clinic is meeting our commitment to diversity, we ask clients to provide the following information. Providing this information is strictly voluntary.

Are you (the client):

_____ Male

_____ Female

Are you (the client) Hispanic or Latino?

____ Yes ____ No

Check one or more of the following groups which you (the client) consider yourself to be a member of:

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or Other Pacific Islander

_____ White

Person completing form _____

Relationship to Client _____

Signature: _____

The Miller Speech and Hearing Clinic shall not discriminate on the basis of race, national origin, religion, age, sex, sexual orientation, or handicapping condition.

I agree to permit Texas Christian University students, enrolled in pertinent academic training programs, to observe and participate in the evaluation and/or treatment procedures which will be conducted under the supervision of the faculty of the clinical programs. In addition, I agree to permit the use of closed-circuit television, the taking of photographs or video recordings, audio recordings, or similar graphic material which are to be used for teaching or scientific purposes.

Signature: _____

I understand that the Miller Speech and Hearing Clinic does not file insurance for clinical services. Upon request, the clinic will supply me with an itemized statement that may be attached to my insurance form and submitted to my insurance company. I understand that all charges incurred are my responsibility and that insurance agreements are between the agency and the client, NOT the agency and Miller Speech and Hearing Clinic.

Signature:_____