



Department of Communication Disorders
 Edgar R. Garrett Speech and Hearing Center
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CASE HISTORY FORM – ADULT

GENERAL INFORMATION

Name: _____ DOB: _____ Male Female

Physical Address, City, State, Zip: _____

Mailing Address, City, State, Zip: _____

Phone #: _____ Email Address: _____

Occupation: _____

Single Widowed Divorced Married Engaged

Spouse's/Partner's Name: _____ Phone #: _____

How did you hear about us?

Word of Mouth Advertisement NMSU Faculty Other: _____

PHYSICIAN & BENEFIT INFORMATION

Primary Physician: _____ Phone #: _____

Are you enrolled in Medicare Part B? Yes No

Do you receive Social Security Disability Insurance (SSDI)? Yes No

DEMOGRAPHIC INFORMATION

Children: (Include Name and Age)

Who lives in the home? _____

What languages do you speak? _____

Level of Education: _____

Describe the reason for evaluation: _____

What do you think may have caused the problem? _____

Have you ever seen a speech language pathologist? If yes, who and when? What were their conclusions or suggestions? _____

Have you seen other specialists (e.g., physicians, audiologists, psychologists, neurologists)? If yes, please indicate the type of specialist, when you were seen and the specialists conclusions or suggestions. _____

Family history of speech, language or hearing problems in your family? If yes, please describe.

MEDICAL HISTORY

Have you had any of the following?

- | | | | | |
|---|--------------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Draining Ear | <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Croup | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Mastoiditis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Otosclerosis | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Colds | <input type="checkbox"/> Noise Exposure | |
| <input type="checkbox"/> Other: _____ | | | | |

Do you have eating or swallowing difficulties? If yes, please describe: Yes No

List all medications you are currently taking

Are you having any negative reactions to your medications. If yes, please describe: Yes No

List major surgeries or hospitalizations (include dates):

Describe any major accidents:

Provide any additional information that may be helpful for evaluation:

Name of person completing this form: _____