ADULT SPEECH LANGUAGE INFORMATION FORM

Please answer the questions as fully and accurately as possible. Your family physician may also be able to provide you with certain information or could send it directly to us if you request it.

Please return this form to:

SUNY New Paltz
Speech, Language and Hearing Center
1 Hawk Drive, HUM 9B
New Paltz, New York 12561
Telephone: (845) 257-3600
Fax: (845) 257-3605

Please fax or send the completed form to us as soon as possible to give us time to review the information before your appointment. All of the information we collect is confidential and is used only by the Speech Language and Hearing Center (SLHC) staff.

Today's date: ___________________

GENERAL INFORMATION:

Patient's name:____Birthdate:________________Sex: _____

Address: ____

Telephone: home and/or cell:____work: _____________________

Occupation:_________________________Employer: ____

Employment address: ____

Education level: ______________________________________

If a student, your current major: ____

Your career objectives: ____

Agency, person or professional who referred you to the SLHC: ________________________________

Name of person filling out this form: ____

Address if different from above: ____

PERSONAL AND FAMILY HISTORY:

Marital status: ________________________

Spouse's name: ____

Children:

Name **Address** **Age**

____

____

____

____

Number of grandchildren: _________

Mother's name:____ Living _______ Deceased _________

If deceased, cause of death: ____

____

Father's name:____ Living _______ Deceased _________

If deceased, cause of death: ____

____

Your native language: ____

Are any other languages spoken in the household? Yes____ No ____ If yes, please describe: ______________

____

Are there any family members with speech, hearing or reading problems? Yes____ No ____

If yes, please explain: ____

____

____

SPEECH AND LANGUAGE INFORMATION:

Describe the problem: ____

____

____

When was this problem first brought to your attention? ____________________________________

Have you had a previous speech and language evaluation: Yes____ No ____

If yes, indicate where, when, by whom, and the findings: ____________________________________

____

____

Have you ever had speech and language therapy? Yes____ No ____

If yes, indicate where, when, by whom, nature of treatment and reason for stopping: ________________

____

____

Has your speech and language changed recently? Yes____ No ____ If yes, explain: __________________

____

____

MEDICAL HISTORY:

General health at this time: ____

____

____

Primary physician name:______________________________ Phone: _______________________

Are you taking medication? Yes____ No ____ If yes, what medications and for what purposes:

____

____

Difficulties eating or swallowing? Yes____ No ____ If yes, describe: ______________________________

____

Vision or eye problems? Yes____ No ____ If yes, describe: ____________________________________

____

Any serious illness? Yes____ No ____ If yes, explain: _______________________________________

____

History of high fevers? Yes____No____If yes, describe the effects: ______________________________

____

History of seizures or convulsions? Yes____ No ____ If yes, describe, including any medications:

____

____

____

Any serious accidents? Yes____ No ____ If yes, describe: ____________________________________

____

Any surgical procedures? Yes____ No ____ If yes, describe: __________________________________

____

Any dizziness or loss of balance? Yes____ No ____ If yes, describe the nature of the problem(s):

____

Have you ever lost consciousness? Yes____ No ____ If yes, describe the causes and the results:

____

Have you ever worn a hearing aid? Yes____ No ____ If yes, describe the hearing loss and type of hearing aids:

____

____

If there are any medical, physical or behavioral problems not listed above, please describe:

____

____

____

Other information you wish to share:

____

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____

Your name (print):____

Signature:____ **Date**: ________________________