

# FONTBONNE UNIVERSITY

*Department of Communication Disorders and Deaf Education*

Eardley Family Clinic for Speech, Language and Hearing

314-889-1407

314 719-8016 (FAX)

**You have requested a speech/language evaluation or therapy. Attached you will find a case history form. Answer the questions as fully and accurately as possible. If you have an IEP or diagnostic report from another institution, please attach a copy. This information will assist the clinic staff in planning and providing for your evaluation or therapy.**

**Return all forms to the speech clinic as soon as possible. We will call you** to schedule an appointment. All evaluations and therapy sessions are conducted by graduate students under the direct supervision of a faculty member or supervisor. All faculty members and supervisors have valid Missouri licenses and ASHA certification.

We offer speech/language evaluations and speech language augmentative communication evaluations as well as therapy for all types of communication disorders. Evaluations are needed if there is no current evaluation or assessment by an ASHA certified speech pathologist.

Individual therapy is offered for all ages. This therapy is typically provided two days a week (Mon & Wed or Tues & Thurs) for one hour each day.

Developmental Language Group (DLG) – This is a group of 6-8 children ages 2-5. We have 3 or 4 clinicians who work within the group. The group runs in the fall, spring and summer, 4 mornings a week, for 2 hours each morning usually from 9:00-11:00 AM.

We also have communication groups for individuals with Aphasia.

**There are no fees for evaluations or therapy services.**

**Students, faculty, staff, and persons served in the program's clinic are treated in a nondiscriminatory manner-that is, without regard to race, color, religion, sex, national origin, participation restriction, age, sexual orientation, or status as a parent. The institution and program comply with all applicable laws, regulations, and executive orders pertaining thereto.**

## Adult Case History-ALS

### GENERAL INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Names of spouse/children \_\_\_\_\_

\_\_\_\_\_

Names and relationships of persons living in the home

\_\_\_\_\_

\_\_\_\_\_

Referred to this clinic by \_\_\_\_\_

### STATEMENT OF THE PROBLEM

Describe your communication problem in as much detail as possible

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Give approximate date when the problem was first noticed \_\_\_\_\_

Did it begin gradually? \_\_\_\_\_ or suddenly? \_\_\_\_\_

What made you aware of the problem? \_\_\_\_\_

Do others have a hard time understanding you? \_\_\_\_\_ yes \_\_\_\_\_ no

Are there times when your speech is better than others? \_\_\_\_\_ If so, when? \_\_\_\_\_

\_\_\_\_\_

Have you used any strategy or AAC device to help you communicate? \_\_\_\_\_  
If so, please describe. \_\_\_\_\_  
\_\_\_\_\_

What is your highest educational level?  
\_\_\_ High School \_\_\_ College/University \_\_\_ Advanced Degree \_\_\_ Other

If any previous evaluations and/or therapy (speech, occupational, and/or physical) was received, please list where and when: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any previous problems your voice/speech/language/communication abilities? \_\_\_\_\_ If so, describe \_\_\_\_\_  
\_\_\_\_\_

MEDICAL HISTORY

Have you had any of the following conditions? (If so, please indicate when)  
Heart Problems \_\_\_\_\_ Throat cancer \_\_\_\_\_ Stroke \_\_\_\_\_  
Hoarseness or loss of voice \_\_\_\_\_ Head injury \_\_\_\_\_ Other \_\_\_\_\_  
Seizures \_\_\_\_\_ Tracheostomy \_\_\_\_\_

Are you currently on any medication? Please list: \_\_\_\_\_  
\_\_\_\_\_

Have you had any chewing or swallowing difficulty? \_\_\_\_\_ If so, describe \_\_\_\_\_  
\_\_\_\_\_

Do you have any difficulty using any muscles? \_\_\_\_\_ If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Physician name \_\_\_\_\_ Physician's phone \_\_\_\_\_  
Address \_\_\_\_\_

Have you had a history of ear trouble? \_\_\_\_\_

Do you have trouble hearing in a group? \_\_\_\_\_ when talking to one person? \_\_\_\_\_  
In church? \_\_\_\_\_ listening to the TV? \_\_\_\_\_ talking on the phone? \_\_\_\_\_

Do you wear a hearing aid? \_\_\_\_\_ dentures? \_\_\_\_\_ glasses? \_\_\_\_\_

ADDITIONAL INFORMATION

Do you use a wheelchair? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Do you use this wheelchair at all times? \_\_\_\_\_

Do you have any difficulty breathing? \_\_\_\_\_

Do you have any difficulty using your hands? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

(Add here anything that you feel might be helpful in the evaluation)

All information is for the confidential use of the Fontbonne University Speech/Language Clinic staff only.

Revised 7/28/2011