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 form 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

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
_____
_____
_____
What do you think caused the problem? _____
_____
_____

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? _____
_____

Has the problem: remained the same? _____ improved? _____
worsened? _____ Comments :

Have you used any strategy or 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 _____
_____

Describe any other speech, hearing or language problems in the family_____
_____
_____

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:_____
_____

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 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