Date Sent:_____
Date Received: _____

INDIANA UNIVERSITY SPEECH-LANGUAGE CLINIC
ADULT HISTORY QUESTIONNAIRE
CONFIDENTIAL

NAME: _____
ADDRESS:_____
_____
(City) (State) (Zip)
Phone (home/cell) :_____Birthdate:_____Place:_____

Age: _____Current Gender Identity:_____

Person or agency who referred you to the Speech-Language Clinic:

Name: _____Address:_____

Phone:_____ _____

Reason for referral:_____

Name of person completing this form:_____

Relationship to client:_____

For what purpose has this evaluation been requested? _____
_____
_____

Please describe the patient's current problem and date of onset:_____
_____
_____

MEDICAL INFORMATION:
1. Physician (s):_____Address:_____
_____ _____

2. Phone:_____ _____

3. Current medication and dosages:_____
_____
_____
_____
_____

4. Does the patient have a history of any of the following?

			Onset Date and Current Status
Stroke	Yes	No	_____
Aphasia	Yes	No	_____
Other communication disorder	Yes	No	_____
Right or left sided weakness	Yes	No	_____
Dementia (e.g., Alzheimer's Disease)	Yes	No	_____
Brain Tumor	Yes	No	_____
Learning Disability	Yes	No	_____
Childhood Speech-Language Delays	Yes	No	_____
Memory Impairment	Yes	No	_____
Other Neurological Disease	Yes	No	_____
High blood pressure	Yes	No	_____
Heart condition	Yes	No	_____
Diabetes	Yes	No	_____
Head Injury	Yes	No	_____
Seizure Disorder	Yes	No	_____
Clinical Depression	Yes	No	_____
Psychiatric Problems	Yes	No	_____
Alcohol Abuse/Problems	Yes	No	_____
Other substance abuse	Yes	No	_____
Other major illnesses	Yes	No	_____
			_____

5. What is the patient's handedness? Right☐ Left☐ Ambidextrous☐

6. Does the client have any weakness or paralysis? _____ If yes, describe _____
_____
_____

7. Does the patient use a cane, walker or wheelchair? _____
_____

8. Does the patient wear glasses/contacts?_____

9. Does the patient have any other visual problems (e.g., right or left visual field cut or cataracts)? _____
_____

10. Does the patient have a hearing loss?_____
Does the patient wear a hearing aid? _____ If yes, in the right ear_____left ear_____both_____

11. How would you describe the patient's general health? _____
_____
_____
_____

12. Please list names and address of physicians/hospitals/clinics that may have relevant medical information. Include speech therapy, audiology, physical therapy, occupational therapy, neuropsychological counseling, psychiatric counseling, and other rehabilitation

Name:	Address:	Dates seen:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

1. Relationships Status:____single ____married ____partnered ____separated ____divorced ____widowed

2. Name/relationship of those living in household:_____
_____

3. Immediate family (name/relationship)	Address (city/state)	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Are there relatives on the patient's side of the family who have had a similar problem with speech and language? If so, who?_____

5. What is the patient's native language?_____
If not English, at what age did the patient learn English?_____

What other languages does the patient speak?_____

6. What is the patient's highest level of education? (schools/dates)_____
_____
_____

7. What (is/was) the patient's primary occupation?_____

Who (is/was) the patient's employer?_____

Is the patient presently working?_____

Describe the patient' work history (for example, kind of employment and approximate dates).
_____
_____

8. Please describe any hobbies, recreational activities, social/civic groups, religious activities, music and movie interests, volunteer work _____
_____

9. Patient's mother's name_____Living_____ Deceased_____

   Patient's father's name _____Living_____ Deceased_____

SPEECH/LANGUAGE/COGNTIVE HISTORY

1. Describe the client's ability to communicate. _____
_____
_____
_____

2. Does the client have any difficulty understanding spoken or written communication? If so, describe
_____
_____
_____
_____

3. Does the client have any difficulty speaking or writing? If so, describe._____
_____
_____

4. Does the client have any difficulty with thinking or memory skills? If so, describe. _____
_____
_____
_____

5. Does the client demonstrate behavioral or personality changes? _____
_____
_____

6. Describe the impact of the speech/language or thinking/memory problem in social and/or work settings.
_____
_____
_____
_____

7. Circle the appropriate answer as it applies currently. Comment where appropriate.

Attempts to communicate verbally	Yes	No	_____
Attempts to communicate in writing	Yes	No	_____
Attempts to communicate using gestures	Yes	No	_____
Uses a device for talking	Yes	No	_____
Can tell you or his or her name and address	Yes	No	_____
Can write his or her name and address	Yes	No	_____
Is speech understandable	Yes	No	_____
Is writing legible	Yes	No	_____
Can communicate in short sentences	Yes	No	_____
Can write short sentences	Yes	No	_____
Can repeat or copy words verbally	Yes	No	_____
Is there automatic speech (e.g., "Hello," "Thank you")	Yes	No	_____
Can understand conversational speech	Yes	No	_____
Can read and understand the newspaper	Yes	No	_____
Can follow daily routine without help	Yes	No	_____
Is easily lost	Yes	No	_____
Has swallowing difficulties	Yes	No	_____
Can remember information from day to day	Yes	No	_____
Can solve safety and interpersonal problems	Yes	No	_____
Is easily distracted	Yes	No	_____

8. Below are words that describe a person's personality and behavior. Circle those words that you feel apply to the patient's present status.

Happy	Fights often	Sad	Enthusiastic	Patient
Very friendly	Warm	Independent	Energetic	Intense
Moody	Critical	Dependent	Prefers to be alone	Jealous
Authoritarian	Supportive	Impatient	Shy	Receptive
Bossy	At ease	Responsive	Cooperative	Relaxed
Active	Indifferent	Distractible	Outgoing	Directive
Tense	Listless	Cold	Can't sleep	Affectionate
Even tempered	Quarrelsome	Vigorous	Easily fatigues	curious
Has temper tantrums	Exhibits control of emotions	Has few fears	Initiates activities	Stays with an activity
Follows the lead of others	Exhibits self help	Walks in sleep	Seeks social relationships	
Waits for recognition	Has many fears	Demands attention	Willing to try unknown	

9. Please write down any additional information you feel will help us in evaluation or treatment decisions.

_____
_____
_____
_____
_____
_____