EASTERN MICHIGAN UNIVERSITY

Dear Client:

Please fill out the enclosed questionnaire as accurately as possible. The information will help us to better prepare for your evaluation. Your answers are confidential. They become part of our clinical records, which will only be released with your consent.

Please complete all sections which may apply. If specific dates, illnesses, etc., are unavailable, please so indicate. We are especially interested in any previous evaluations, educational services or medical services you may have received.

Also included are a Release of Information form and an Authorization form. The blue Release will allow us to send our reports to professionals that you designate. The green Authorization indicates your acceptance that students-in-training will be involved with your evaluation and allows us to make appropriate professional use of the information you have provided. The bottom portion of this form will provide us with information for billing (Unless otherwise indicated on this form, services will be billed to the client.).

THESE FORMS MUST BE COMPLETED BEFORE AN APPOINTMENT CAN BE SCHEDULED.

Please return these completed forms to:

Speech and Hearing Clinic Suite
135 Porter Building Eastern
Michigan University Ypsilanti,
Michigan 48197

When we have received all of the completed and signed forms, we will activate file and contact you when we have an opening.

Sincerely,
Speech and Hearing Clinic Staff

EASTERN MICHIGAN UNIVERSITY'S SPEECH AND HEARING CLINIC IS ACCREDITED
FOR CLINICAL-SERVICES BY THE COUNCIL FOR PROFESSIONAL SERVICES ACCREDITATION
OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION (ASHA).

EASTERN MICHIGAN UNIVERSITY

COLLEGE OF EDUCATION CLINICAL SUITE

SPEECH AND HEARING CLINIC

Suite 135 Porter Building - Ypsilanti, MI 48197 - Phone: (734) 487-4410

ADULT SPEECH-LANGUAGE CASE HISTORY

Form Completed By	Relationship to Client	Date

CLIENT IDENTIFICATION

Last Name	First Name	Nickname	Sex	Age	D.O.B

Street Address	Apt #	City	State	Zip

Home Phone	Work Phone	Cell Phone
( )	( )	( )

REFERRAL INFORMATION

Referred By	Agency	Phone
		( )

Street Address	Suite/PO Box	City	State	Zip

EDUCATION

IF YOU ARE CURRENTLY ENROLLED IN CLASSES, PLEASE PROVIDE THE FOLLOWING:		
Name of School	Area of Specialization	Level
IF YOU ARE NOT CURRENTLY ATTENDING CLASSES:		
Name of School	Area of Specialization	Last Level Completed

EMPLOYMENT

Occupation	Type of Work	Hours/Week

Employer	Phone	If Retired, Date of Retirement
	( )	

Previous Employment

FAMILY INFORMATION

Marital Status (Please Circle One)	Name of Spouse/Significant Other
Married / Divorced / Separated / Widowed	

Address of Spouse/Significant Other

Occupation	Hours/Week	Employer	Phone
			( )

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR CHILDREN				
Name	Age	Sex	City	State

IF THERE ARE ANY OTHERS LIVING IN YOUR HOME, PLEASE LIST RELATIONSHIP

SPEECH AND LANGUAGE INFORMATION

Native Language	Other Languages Spoken in Your Home:

Other Languages You Read	Other Languages You Write

DESCRIBE YOUR PRESENT SPEECH/LANGUAGE PROBLEMS

Please Describe Any Family/Social Problems Caused By Your Speech/Language Problems

Please Provide Age and Description of any Speech/Language Problems Prior to one Described Above

LIST ANY PREVIOUS SPEECH/LANGUAGE EVALUATIONS OR THERAPY		
DATES	PLACE	TYPE OF HELP RECEIVED

HEARING INFORMATION

DO YOU HAVE TROUBLE HEARING: Y/N
Normal Conversation? In a Group? TV? Motion Pictures? Radio? Telephone? Other?

IF YOU HAVE A HEARING LOSS:		
Age at Onset	Right, Left or Both Ears	Cause

HAVE YOU CONSULTED A PHYSICIAN REGARDING THE HEARING LOSS?	

Do You Experience:	Y	N	If Yes, have you consulted your Physician?
Pain in your Ear(s)			
Frequent Middle Ear Problems/Fluid			
Ringing/Noises in your Ears/Head			
Dizziness or Balance problems			

HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING LOUD SOUNDS WITHOUT HEARING PROTECTION?				
	Yes	When	How Long	No
Rifle/Artillery				
Factory/Industrial				
Construction				
Music				
Other				

IF YOU HAVE A FAMILY HISTORY OF HEARING LOSS	
Relationship	Description of Loss

IF YOU WEAR A HEARING AID		
EAR	TYPE	AGE

Who prescribed/fitted the aid?	
Date of last appointment?	
Hours per day aid is worn?	
Does your aid require repair/replacement?	

MEDICAL INFORMATION

FAMILY PHYSICIAN			
Name:	Phone: ( )		
Street Address	Suite	City	Zip

SPECIALISTS			
Name:	Phone: ( )		
Street Address	Suite	City	Zip
Name:	Phone: ( )		
Street Address	Suite	City	Zip

IF THERE IS A MEDICAL REASON FOR YOUR SPEECH/LANGUAGE PROBLEM, PLEASE DESCRIBE AND DATE OF INCIDENT/OCCURRENCE

	Yes	Please Describe	No
Were you unconscious?			
Were you paralyzed?			
Did you have seizures?			
How soon were you seen by a physician?			

IF YOU WERE HOSPITALIZED:			
Name of Hospital	City	State	How Long?

IF YOU ARE NOW UNDER A PHYSICIAN'S CARE, PLEASE EXPLAIN REASON

IF YOU ARE TAKING MEDICATION PLEASE PROVIDE THE FOLLOWING INFORMATION:		
Name of Medication	Dosage	Reason for taking

Any known Allergies? If so, please list:

EASTERN MICHIGAN UNIVERSITY
COLLEGE OF EDUCATION CLINICAL SUITE
COUNSELING CLINIC ♦♦ READING CLINIC ♦♦ SPEECH AND HEARING CLINIC
Suite 135 Porter Building • Ypsilanti, MI 48197 • phone: (734) 487-4410 • fax: [redacted]

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
FOR ______________________________

I, ______________________________, hereby authorize the College of Education Clinical Suite at Eastern Michigan University to exchange/release information in:

☐ my own record ☐ my spouse's record date of birth ____________

☐ my child's record

to the individual or organization listed below, and only under the conditions specified.

1. THE REPORTS WILL BE SENT TO YOU: COMPLETE THE INFORMATION BELOW.

NAME ______________________________

STREET ______________________________

CITY ______________________ STATE ______ ZIP ________

2. SPECIFIC TYPE OF **INFORMATION** TO BE DISCLOSED

	Diagnosis		Substance use Records		Academic/School Records
	Treatment Plan		Ideological Records		Employment Records
	Final Report/Treatment Outcome		Evaluation		Court Records
	Medical Records and Reports		Psychological Records		Other (please specify below)

3. THE PURPOSE AND NEED FOR SUCH DISCLOSURE

	Assessment and treatment planning		Court Ordered		Coordination of treatment
	Other				

4. I UNDERSTAND THAT THIS CONSENT CAN BE REVOKED BY ME AT ANY TIME, IN WRITING. UNLESS I CHOOSE TO EXERCISE MY RIGHT OF REVOCATION AT AN EARLIER DATE, THIS CONSENT EXPIRES:

	One year from date signed		When requested information has been supplied
	At the end of the current academic semester		At termination of treatment
	Other (please specify)		

______________________________ ______________________________

WITNESS CLIENT/GUARDIAN SIGNATURE

______________________________ ______________________________

DATE WITNESSED DATE SIGNED

I/ My child attend (s) the: ☐ COUNSELING CLINIC ☐ READING CLINIC ☐ SPEECH AND HEARING

EASTERN MICHIGAN UNIVERSITY
COLLEGE OF EDUCATION CLINICAL SUITE
SPEECH AND HEARING CLINIC

Suite 135 Porter Building • Ypsilanti, MI 48197 • Phone: (734) 487-4410 • Fax:

AUTHORIZATION

CLIENT'S NAME		BIRTHDATE	
PARENT'S / GUARDIAN'S NAME		RELATIONSHIP	

PHONE NUMBERS				
PHONE	CLIENT	MOTHER	FATHER	GUARDIAN/SPOUSE
HOME	( )	( )	( )	( )
WORK	( )	( )	( )	( )

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (IF NOT LISTED ABOVE)		
NAME	RELATIONSHIP	PHONE
		( )

I hereby authorize the Eastern Michigan University Speech and Hearing Clinic to make customary and constructive use, exercising due discretion, for education, scientific and professional purposes, and in the public interest of information, photographs, sound recordings, video recordings, and other records and materials pertaining to, and in consideration of, my enrollment, examination, instruction, and scientific participation, or that of my minor child, ____________________, or that of ______________________, for whom I am legally responsible, in the Speech and Hearing Clinic. I understand that the services in the clinic are rendered by students as a part of their training program.

______________________________ ______________________________

Signature Date

*Please note: We do not accept or bill Medicare, Medicaid, nor any other insurance.