Speech and Hearing Center
Department of Communication Sciences and Disorders
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ADULT HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Name: ______________________________________ Date: _________________________
Age: ________ Date of Birth: ___________________Gender: _________M __________F
Address: ____
____
Person completing questionnaire, if different than above: __________________________
Relationship to client: ___________________Referred by: __________________________

Family Physician: ___________________________________ Phone: _________________
Insurance Company: _________________________________ Provider # _______________
HMO Yes _____ No _____ Prior Approval Required? __________________

II. DESCRIPTION OF COMMUNICATION

Describe any communication difficulty you are experiencing. Please include when you first noticed it and what you think caused it. _____________________________________
____
____
____

Do you every have difficulty understanding people when they talk to you? If so, please describe. ____
____
____

What question(s) would you like answered as a result of an evaluation here? ___________
____
____
____

NOTE: All information provided on this form will be held in the strictest confidence.
What would you like to change about your communication? ______________________
____
____
____

What difference would such change(s) make in your daily activities at home and/or at work? ____
____
____

Describe the reaction of people, including your immediate family, to your communication difficulty. ____
____
____

Describe anything you have done to address your communication difficulty. ___________
____
____

Describe particular situations which make it difficult for you to communicate. __________
____
____

III. FAMILY HISTORY

Marital Status: ____Married ____Widowed ____Separated ____Divorced ___Single

Name of Spouse: ____
Age: _____ Education: ____
Employer: ______________________________ Occupation: ____________________

Children:

Name: ____Age: ____________________
Name: ____Age: ____________________
Name: ____Age: ____________________

Others living in the home: ____
Language(s) spoken in the home: ____

Other family members with speech, language or hearing problems, and if so, please describe: ____
____
____

IV. HEALTH HISTORY

Present physical condition:
Height: _______ Weight: _______ Status of vision: __________
Condition of teeth: _____________ Motor coordination: __________
Any dizziness? ___________

Are you presently under the care of a physician? __________ If so, please explain: ______
____
____

Check any medical condition(s) that may or may not be related to your communication.

_____Vocal nodules	_____ Aneurysm	_____Stroke	____Alzheimer's Disease
_____ Laryngectomy	_____ Thrombosis	___right side	____Parkinson's Disease
_____ Loss of Voice	_____ Heart disease	___left side	____Other _________
_____ Seizures	_____ Diabetes	_____Learning Disability	_________

Please list any medication(s) you are currently taking:

___________________________________ ____________________________________
___________________________________ ____________________________________

Are you experiencing any of the following symptoms?

Symptom	**Yes**	**No**
Decrease in Hearing	____	____
Ringing in Ear	____	____
Ear Pain, Fullness	____	____
Vertigo, Dizziness	____	____
Nausea	____	____
Headaches	____	____
Cold, Sinus, Allergy	____	____
Recent Noise Exposure	____	____

Do you wear hearing aids? ____Yes ____ No If yes, what kind? ______________

Describe any physical disabilities: ____
____
____

Illnesses:

	Approximate Age	Duration	Severity and/or Complications
Measles (Yes/No)	____	________	____________________________
Rubella (Yes/No)	____	________	____________________________
Mumps (Yes/No)	____	________	____________________________
Jaundice (Yes/No)	____	________	____________________________
Diabetes (Yes/No)	____	________	____________________________
Allergies (Yes/No)	____	________	____________________________
High Blood Pressure (Yes/No)	____	________	____________________________
Very High Fevers (Yes/No)	____	________	____________________________

Other: ____

Operations or Injuries:

	Approximate Age	Outcome
Tonsillectomy	___________	_________________________________
Adenoidectomy	___________	_________________________________
Ventilation Tubes	___________	_________________________________
Head Injury	___________	_________________________________

Other: ____

Lifestyle Habits:

Do you exercise? ____ If so, how often? Seldom ____ Occasionally ____ Frequently ____
Do you smoke? ____ If so, how much? ____
Do you drink? ____ If so, how often? Seldom ____ Occasionally ____ Frequently ____

Do you have any dietary restrictions? ____ If yes, what are they? ____________________
____
____

V. EDUCATION, OCCUPATION, AND INTERESTS

Education: Mark the highest grade attended:

1 2 3 4 5 7 8 9 10 11 12

College: 1 2 3 4

Education beyond college? ____

Recent Employment: List employers, dates employed, and nature of work performed. Include both full and part-time employment.

Employer	Approximate Dates	Nature of Work
____________	__________________	_____________________________
____________	__________________	_____________________________
____________	__________________	_____________________________
____________	__________________	_____________________________
____________	__________________	_____________________________

Describe any special interests or hobbies: _____________________________________
____
____
____

List other activities (church, community, volunteer work, etc.): ____________________
____
____
____
____
____

VI. PERSONALITY CHARACTERISTICS

Read quickly through the following list of adjectives and circle those characteristics which describe you.

happy	warm	sad	very friendly	critical
independent	moody	authoritarian	dependent	jealous
receptive	supportive	shy	cooperative	bossy
responsive	resigned	relaxed	indifferent	distractible
resistant	troubled	listless	outgoing	tense
even tempered	cold	affectionate	easily fatigued	quarrelsome
vigorous	fearful	curious	forgetful	temperamental
enthusiastic	impatient	social	energetic	active
angry	directive	can't sleep	confused	

VII. OTHER EVALUATIONS

Have you seen other professionals concerning your communication?____ If so, please enter the names of persons who have been consulted, their addresses, professions and dates of your contact with them. Please give your impressions of the outcomes of the professional's service. Include physicians, speech and language pathologists, audiologists, teachers, and hearing aid dealers whom you have consulted.

Name: ________________________________ Address: ____________________________
____
Profession: ____________________________ Date: ________________________________
Outcome: ____

Name: ________________________________ Address: ____________________________
____
Profession: ____________________________ Date: ________________________________
Outcome: ____

Name: ________________________________ Address: ____________________________
____
Profession: ____________________________ Date: ________________________________
Outcome: ____

We would like to have reports from professionals who may be able to help us better understand your communication difficulty. A phone call and/or written request from you is necessary in order for a report to be released to us. Enclosed is a form for making written requests.

VII. ADDITIONAL INFORMATION

Please write any additional information you think will help us in understanding your concerns. ____
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