San Francisco State University
Communicative Disorders Clinic

Date:_____
Clinician:_____
Supervisor: _____

F-39: Adult Client History—Speech-Language Pathology

Name _____

Birthdate _____ Sex: **M** **F** Age: _____

Address _____

City/State/Zip _____

Phone: home: ( ) work: ( ) cell: ( )

Referred by: _____

Agency: _____

Description of Problem_____

_____

_____

_____

_____

When did you become aware of the problem?_____

_____

Does your speech problem vary? (during day/situations)_____

_____

What have you done about your speech problem? _____

_____

Other Persons Living in the Home

Name	Relationship	Age

Primary Language spoken in home:_____

Other languages spoken:_____

Has anyone in your family had: (if so, please specify)

Speech problems: _____

*Learning problems:*_____

Behavioral problems: _____

*Seizures:*_____

*Allergies:*_____

*Chronic Illness of any kind:*_____

If any members of your family ever had had special help with a psychologist, social worker, psychiatrist, speech therapist, medical specialist (neurologist, orthopedist, ENT physician, etc.), please comment:

_____

_____

MEDICAL and HEALTH HISTORY. Please check those medical and health problems which you have had and indicate your age at the time of illness)							
PROBLEM	YES	NO	AGE	PROBLEM	YES	NO	AGE
allergies or hay fever				high blood pressure			
arthritis				hormone therapy			
asthma				incoord. of face/tongue muscles			
broken nose				influenza			
chronic colds				menopause			
chronic laryngitis				mouth breather			
convulsions				mumps			
diabetes				pneumonia			
diphtheria				poliomyelitis			
ear disease				post nasal drip			
earaches				random purposeless movements			
epilepsy				rheumatic cold			
gait pecularities				scarlet fever			
gastric problems				sinus problems			
heart attack				smoking			
hiatal hernia				typhoid			
hiatal hernia with reflux				Other			

List and describe hospitalizations, including emergency room visits. Give reason for visit as well as date:

_____

_____

Describe your general health:_____

Are you currently under medical treatment or on medication? If so, please describe:

_____

Has your hearing ever been tested?_____ When?_____ Where?_____

Results:_____

Do you have any of the following?

Vision problem: _____ *Glasses:*_____ *Hearing problem*: _____

Cleft palate: _____ *Fistula:*_____ *Hearing aid*:_____

*Abnormality of tongue, jaw, teeth or lips:*_____

Emotional or behavioral problems _____

*Other physical disability:*_____

Have you been seen by any other specialist? If so, list name of specialist seen, and purpose of visit:

_____

EDUCATION (List the schools attended)		
School	City	Date and Grade Levels

Grade Completed: 1 2 3 4 5 6 7 8 High school College Graduate

What is your biggest concern at this time (Hearing, speech, language, medical, education, social, other).

Please describe:_____

_____