Calvin Speech Pathology and Audiology
Calvin Speech & Hearing Clinic
On the campus of Calvin University | North Hall
616.526.6070 · f. 616.469.1355

CALVIN SPEECH & HEARING CLINIC APPLICATION
ADULT CASE HISTORY FORM

We appreciate your effort to attend all sessions. Successful treatment depends upon a weekly commitment; and students spend many hours in preparation for each client's sessions. Absence of 3 or more sessions in a semester may result in losing your time slot.

Date of Application: _____ ☐ Virtual appointments ☐ In-person appointments ☐ Either

Session Applied for: _____ ☐ Individual ☐ Aphasia Groups

Name: _____ Date of birth: _____

Address: _____

_____

Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____

Family physician & Location: _____

Referring physician & Location: _____

Person filling out this form (check one): ____Self ____Other (name): _____

Name of guardian/caregiver or spouse (if applicable): _____

Emergency Contact: _____

What is your primary language: What other languages do you speak?

What was the highest grade, diploma, or degree you earned?

MEDICAL HISTORY

Provide the approximate ages at which you suffered the following illnesses or conditions:

Acid reflux_____ Adenoidectomy_____ Asthma_____
Cancer_____ Chicken pox_____ Chronic laryngitis_____
Cleft palate_____ COPD_____ Diabetes_____
Draining ears_____ Ear infections_____ Facial nerve palsy_____
Head injury_____ Heart attack_____ Hypertension_____
Hearing loss_____ Measles_____ Meningitis_____
Mumps_____ Otosclerosis_____ Pneumonia_____
Seizures_____ Stroke_____ Tinnitus_____
Other:_____

What is your current state of health? ____ Excellent ____ Average-Fair ____Poor

Do you have hearing or swallowing difficulties? If yes, describe.

Have you been hospitalized within the last 5 years? If so, why? Where?

List all of the medications you are taking.

Describe any major accidents or current medical conditions.

Do you use any of the following assistive devices?

_____Wheelchair
_____Walker
_____Cane
_____Other_____
_____None

SPEECH-LANGUAGE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty Swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding others			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness			
Voice Difficulties			
Other:			

Did the problem begin suddenly or develop over time?

Have you been seen by any other rehabilitation professional?

_____Speech therapy: Where: _____When:_____

_____Physical therapy: Where: _____When:_____

_____Occupational therapy Where: _____When:_____

Describe your daily communication needs:

What do you hope to get out of speech-language therapy?

Is there anything else you think we should know?

Please return this completed form by one of the following ways:

Mail: Calvin Speech & Hearing Clinic
Calvin University
3201 Burton St SE
Grand Rapids, MI 49546
Fax: 616-469-1355 By email: spaud@calvin.edu

Find out more about our clinic: www.calvin.edu/go/SpeechClinic

For driving directions to our clinic (North Hall): http://www.calvin.edu/map/
Contact phone number: 616-526-6070.

The Calvin University Speech Pathology and Audiology Program is committed to the principle of equal opportunity. We do not discriminate on the delivery of professional services on the basis of race, color, religion, sex, national or ethnic origin, disability, age, sexual orientation, genetic information, citizenship, status as a covered veteran, or other characteristics protected by federal, state, or local statue or ordinance.