California State University, Fresno
Speech, Language and Hearing Clinic

5310 North Campus Drive M/S PH 80
Fresno, California 93740-8019
(559) 278-2422 ◆ Fax (559) 278-5187

ADULT CASE HISTORY

PLEASE PRINT IN INK OR TYPE ALL INFORMATION

General Information

Today's Date: _____

Please Check One ☐ Hearing Evaluation ☐ Diagnostic ☐ Individual Speech Therapy
☐ Bilingual Clinic

**I am Medicare Part B Eligible ☐ YES ☐ NO

Name: _____ **Date of Birth:** _____ **Gender:** ___

Address: _____ **Email:** _____

City: _____ **Zip:** _____

Occupation: _____ **Cell Phone:**_____

Employer: _____ **Home Phone:** _____

Please Check One: Single Widowed Divorced Married

Spouse's Name: _____ **Spouse's Occupation:** _____

Names, ages, and gender of children: _____

_____

Referred By: _____ **Phone:**_____

Address: _____

Have you been tested and/or evaluated at this clinic before? _____

If yes, how long ago was your last visit? _____

Office Use Only:

Date Received: _____

Dates Contacted: _____

Names and relation of other persons living in home: _____

What languages do you speak? _____

What is your primary language? _____

Highest grade completed or degree earned? _____

Describe your speech-language or hearing problem: _____

_____

_____

What do you think caused the problem? _____

_____

_____

When did you first notice the problem? _____

_____

_____

How has the problem changed since you first noticed it? _____

_____

_____

How has your communication problem affected your life? _____

_____

_____

List other speech-language specialists or audiologists you have seen and describe their conclusions or recommendations: _____

_____

List any other specialists (physicians, psychologists, neurologists, etc.) you have seen, and the specialists' conclusions or suggestions: _____

_____

Describe any other speech, language, learning, or hearing problems in your family: _____

_____

_____

_____

Medical History

General Health is: ☐ Good ☐ Fair ☐ Poor

Provide the approximate ages at which you experienced the following illness and conditions:

Adenoidectomy _____	**Allergies** _____	**Asthma** _____
Chicken pox _____	**Colds** _____	**Convulsion** _____
Croup _____	**Diabetes** _____	**Draining ear** _____
Ear Infections _____	**Dizziness** _____	**Epilepsy** _____
Headaches _____	**Encephalitis** _____	**German Measles** _____
Influenza _____	**Hearing Aids** _____	**Heart problems** _____
Meningitis _____	**Hearing Loss** _____	**High fever** _____
Numbness _____	**Mastoiditis** _____	**Measles** _____
Otosclerosis _____	**Mumps** _____	**Noise Exposure** _____
Sinusitis _____	**Paralysis** _____	**Seizures** _____
Tonsillitis _____	**Pneumonia** _____	**Tonsillectomy** _____
Ulcers _____	**Visual Problems** _____	**Glasses** _____
Do you smoke? _____	**How much per day?** _____	

List all prescription and nonprescription medication used during the past year: _____

_____

_____

Describe any eating or swallowing difficulties you have experience: _____

_____

_____

List any major accidents, illnesses, surgeries, or hospitalizations (include dates): _____

_____

_____

_____

Provide any additional information that you might believe to be helpful in the evaluation or remediation process: _____

_____

_____

_____

_____

PLEASE ATTACH ANY REPORT YOU HAVE FROM ANOTHER AGENCY, SCHOOL, OR DOCTOR.

Person completing the form: _____

Relationship to client: _____

Signed: _____ **Date:** _____

****Please Note:** You must complete and sign the attached Observation and Photo/Video Consent statements, and the Release of Liability form and return them with your case history form. Thank you for taking the time to fill out the forms completely and accurately.

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Observation Consent

Consent is hereby given to faculty, students and other persons approved by the clinical supervisor at the Language, Speech and Hearing Clinic at California State University, Fresno to observe _____ in the clinic or in off campus settings.
Client Name

The purpose of these observations is to train University Communicative Sciences & Disorders students (both diagnostic and treatment sessions may be observed). Students from other departments studying children and adults with language, hearing, and speech disorders may also watch and listen if the supervisor gives permission.

_____ _____

Parent/Guardian/Self (18 or older) **Date**

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Consent and Release for Photographs or Videotaping

Consent is hereby given to the Speech, Language, & Hearing Clinic, at California State University, Fresno, to take photographs, or videotape of _____.
I understand that the photos/videos will be used to train University students and demonstrate department activities to the general public (e.g. CDDS department website or on Professional Health Services building bulletin boards).

I understand that I will be able to view the photographs or videotape if I request to do so.

_____ _____
Parent/Guardian/Self (18 or older) – Print Name **Date**

_____
Signature

RELEASE OF LIABILITY, PROMISE NOT TO SUE, ASSUMPTION OF RISK AND AGREEMENT TO PAY CLAIMS

Activity: Participation in evaluation and/or treatment in the California State University Speech and Hearing Clinic

Activity Date(s) and Time(s): Ongoing
Activity Location(s): PHS 101, 220, 222, 225, 248

In consideration for being allowed to participate in this Activity, on behalf of myself and my next of kin, heirs and representatives, **I release from all liability and promise not to sue** the State of California; the Trustees of The California State University; California State University, Fresno; The California State University Association, Inc.; California State University, Fresno Foundation, Inc.; California State University Athletic Corporation; and all of said entities' employees, officers, directors, volunteers and agents (collectively "University) from any and all claims, **including claims of the University's negligence,** resulting in any physical or psychological injury (including paralysis and death), illness, damages, or economic or emotional loss I may suffer because of my participation in this Activity, including travel to, from and during the Activity.

I am voluntarily participating in the Activity. I am aware of the risks associated with traveling to/from and participating in this Activity, which include but are not limited to physical or psychological injury, pain suffering, illness, disfigurement, temporary or permanent disability (including paralysis), economic or emotional loss, and/or death. I understand that these injuries or outcomes may arise from my own or other's actions, inaction, or negligence; conditions related to travel; or the condition of the Activity location(s). **Nonetheless, I assume all related risks, both known or unknown to me, of my participation in this Activity, including travel to, from and during the Activity.**

I agree to **hold** the University **harmless** from any and all claims, including attorney's fees or damage to my personal property that may occur as a result of my participation in this Activity, including travel to, from and during the Activity. If the University incurs any of these types of expenses, I agree to reimburse the University. If I need medical treatment, I agree to be financially responsible for any cost incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I am 18 years or older. **I understand the legal consequences of signing this document, including (a) releasing the University from all liability, (b) promising not to sue the University, (c) and assuming all risks of participating in this Activity, including travel to, from and during the Activity.**

I understand that this document is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms.

I have read this document, and I am signing it freely. No other representations concerning the legal effect of this document have been made to me.

Participant Signature: _____

Participant Name (print): _____ Date: _____

If participant is under 18 years of age, or has a legal conservator or guardian:

I am the parent or legal conservator/guardian of the Participant(s) listed below. **I understand the legal consequences of signing this document, including (a) releasing the University from all liability on my and the Participant's behalf, (b) promising not to sue on my and the Participant's behalf, (c) and assuming all risks of the Participant's participation in this Activity, including travel to, from and during the Activity.** I allow Participant to participate in this Activity. I understand that I am responsible for the obligations and acts of Participant as described in this document. I agree to be bound by the terms of this document.

I have read this two-page document, and I am signing it freely. No other representations concerning the legal effect of this document have been made to me.

_____
Signature of Participant's Parent or Legal Guardian/Conservator

_____
Name of Participant's Parent or Legal Guardian/Conservator (Print)

_____
Minor Participant Name(s)