LSU Health NEW ORLEANS
School of Allied Health Professions

Department of Communication Disorders, Speech Language Pathology
1900 Gravier Street, 9th Floor, New Orleans, La 70112

Adult Case History Questionnaire

Today's date: _____
Patient's legal name: _____ Birthdate: _____ Age: _____
Preferred name: _____ Preferred pronouns: _____
Sex Assigned at birth: _____ Gender Identity: Male Female Non-binary/Gender Fluid
Self-Identity: _____ Do you consider yourself to be of transgender experience? ____
Marital Status _____

**While LSUHSC recognizes several genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your correct name and pronouns are different from these, please let us know.*

Address: _____

Preferred Phone: (_____) _____ Secondary Phone: (_____) _____
Person(s) completing questionnaire: _____ Phone: (_____) _____
Relationship to patient: _____
Referred by: _____ Phone: (_____) _____
Reason for referral:_____
_____

Statement of the Problem

Please describe the communication problem fully. You may continue your description on the back of this sheet if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What do you expect from this evaluation?

_____
_____

What questions would you like answered from this evaluation?

_____

Are you seeking an evaluation to get a communication device? _____

Are you interested in speech therapy? _____

Employment and Family History

Patient's Birthplace _____

Is the patient currently employed? Yes ____ No ____Is the patient retired? Yes_____ No_____

If yes, for how long? _____

Place of employment _____

How long has the patient had their current occupation? _____

Has the patient's speech/hearing problem caused a change in jobs? _____

Explain_____

Is the patient's working environment noisy? _____

Spouse's Name _____Spouse's Age _____

List all the patient's children

_____

_____

_____

Who lives at home with the patient?_____

Preferred language:_____ First language: _____

Other languages spoken at home: _____

Medical Information

Please list all the patient's medical diagnoses:

_____

_____

_____

_____

_____

Patient's primary care doctor: _____Phone: (_____) _____

Please list all the patients' current medications:

Medication Dosage Purpose

_____

_____

_____

_____

List all the patient's physical disabilities

_____

_____

_____

_____

Does the patient believe they have hearing loss? Yes_____ No _____

Does the patient have any visual problems? Yes_____ No_____

Does the patient have any known cognitive disabilities, either new or from birth? Yes ____ No ___ (specify)

_____

Has the patient had a psychological evaluation? Yes_____ No _____

Method of mobility (please check all that apply):

_____ Walks Unassisted _____ Walks Assisted _____ Stroller _____ Wheelchair.

Most reliable movement patterns:

___ Pointing ____ Raising Arm ____ Eye Pointing ____Other (specify) _____

Self-Help Skills (if applicable)

Does the patient:

Feed themselves? Yes ____ No ___ Dress themselves? Yes___ No____

Uses the toilet independently? Yes___ No___

If not, does then patient require:

_____ Partial assistance _____ Complete assistance

Educational history (if applicable)

What was the highest level the patient achieved in school? _____

Social History (please complete all that apply)

Place of residence:

___Private family home ___Nursing home ___Group home ___Other _____

What percentage of a typical day is the patient at:

_____Home _____Work _____School _____Other_____

What percentage of a typical day is the patient:

_____In a wheelchair _____In chair _____In bed _____With walker _____On floor

_____Side lying _____Other _____

List places the patient frequently visits:

_____

List significant people in the patient's life:

_____

List significant objects in the patient's life:

_____

List the patients hobbies:

_____

Adaptive Equipment (If applicable)

Please check all adaptive equipment the patient uses:

_____ Hearing Aid _____ Glasses _____ Walker _____ Wheelchair____ Communication equipment

_____ Others (specify) _____

Communication (if applicable)

Does the patient have trouble understanding speech? Yes_____ No_____

Does the patient attempt to communicate? Yes____ No____

Does the patient initiate communication? Yes____ No____

Who does the patient attempt to communicate with? _____

Please indicate all means of communication currently used: (If possible, rank order from most to least frequently used; 1 being most frequently used, etc.)

Speech _____ Eye pointing _____

Vocalization _____ Spoken "yes-no" _____

Manual Signing _____ Gestural "yes-no" _____

Bodily Gestures _____ Communication Device ____

Facial Expression ____

If the patient speaks, please check if the speech is:

___Understood by strangers ___Understood by family/friends only.

___Difficult for family/friends to understand ___Is never understood by others.

Circle any of the following that describes the patient's voice:

Often hoarse	High-pitched	Low-pitched	Very loud
Too soft	Easily tired	Breaks in voice	Normal

Does the patient experience any of the following?

____Difficulty understanding others ____Difficulty to get others to understand them.

____Difficulty finding the right word ____Difficulty expressing what they want to say.

____Difficulty swallowing _____Difficulty reading and comprehending.

Has anyone looked at the patient's vocal cords and/or soft palate? If yes, what did they find?

_____

_____

Does the speech/hearing problem cause difficulty in day-to-day living (including educational, social, or vocational plans)? _____

Does the patient use any of the following? Please indicate:

_____Natural gestures (handshake for no, pointing)
_____Signing Exact English
_____American Sign Language
_____Amer-Ind Gestural Code
_____Sign System
_____Pantomime
_____Finger Spelling
_____Other (specify)_____

Does the patient use communication boards, electronic devices or other communication systems to communicate? (specify) _____

Therapy History

Has the patient ever had, or are they currently receiving, speech, physical, or occupational therapy? (specify) _____

Support Services

Does the patient have a social worker? Yes _____ No_____

Name: _____ Phone: _____

Indicate agencies for possible financial assistance:

_____ Medicaid _____ Private insurance _____ SSI ____ Medicare _____Service group

____ Church group _____ Other_____

If there is additional information which you feel will help us to understand the individual and his/ her problem better, please describe:

_____

_____

_____