RiteCare Center For Communication Disorders

Armstrong State University
11935 Abercorn Street
Armstrong Center Suite 20
Savannah, Georgia 31419-1997
Phone: 912.344.2969
Fax: 912.344.3439

PLEASE RETURN COMPLETED FORMS AS SOON AS POSSIBLE.
YOU WILL BE CONTACTED FOR AN APPOINTMENT
AFTER THIS OFFICE RECEIVES THE FORM.

Case History – Adult

Date: _____ Referred by: _____

Identifying Information

Name: _____ Date of Birth_____ Age _____

Address: _____
(Street/Route) (City & State) (Zip Code)

Place of Employment: _____ Occupation: _____

Phone: _____ Phone: _____ Education: _____
(Home) (Work)

Number of brothers and/or sisters _____

Marital Status: _____ Number of children _____

Name of Spouse: _____

Place of Employment: _____ Occupation: _____

Name & address of Physician: _____

_____

Name of person/s completing this form & relationship to patient: _____

_____

Revised 4/2015

Speech, Voice & Hearing History

Describe your speech, voice or hearing problem. (What has been bothering you that prompted you to set up this appointment?)

Who first noticed the problem and when? _____

_____

Under what circumstances was the problem noticed? _____

Has it become better or worse? Describe any changes. _____

What do you feel is the cause of the problem? _____

Indicate any medications you take regularly. _____

If any family members have any type of speech, voice or hearing problems please describe.

_____

If you ever had any treatment for your problem please describe the results of that treatment.

_____

List the names, agencies, therapists, or counselors you nay have seen. If you have ever had speech therapy, hearing therapy or counseling, include the dates.

_____

_____

Have you ever worn a hearing aid (give type of aid, who recommended it, and how long you have used it)?

_____

Please give any additional information related to the problem.

_____

_____

Please list any conditions that you have been diagnosed with by a medical doctor or a psychologist:

_____

_____

Please list any medications and dosages that you are currently taking: _____

_____

Please list any allergies you have: _____

Please read and sign:
I understand that the Armstrong State University RiteCare Center For Communication Disorders is a training facility for student-clinicians in the Speech-Language Pathology Program. I understand that student-clinicians under the supervision of a licensed, certified Speech-Language Pathologist render communication diagnostic and therapy services. I authorize the Armstrong State University RiteCare Center For Communication Disorders Clinic to provide services to me.

_____ _____

(Signature) (Date)

PLEASE RETURN COMPLETED FORMS AS SOON AS POSSIBLE.
YOU WILL BE CONTACTED FOR AN APPOINTMENT
AFTER THIS OFFICE RECEIVES THE FORM.