**MULTICULTURAL ADULT CASE HISTORY FORM**

*Please fill out this form as completely as possible, especially the items marked with an asterisk. If you needmore space, attach another page, or write on the back. Call 422-2870 if you have additional questions regarding these forms.*

Date:

**\***Name: **\***Birthdate: **\***Age:\_\_\_\_\_\_\_\_ Gender: F M

Phone: (home) (cell) (work)

Best time to call: Email:

Address:

City: State: ZIP:

Spouse or responsible party: Age:

**\***Reason for referral: Referring person:

Country of Origin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years have you lived in the US?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Birth History

**\***Do you know of any difficulties during pregnancy, labor, or delivery?

What was your mother's age: and health: at your birth?

Did you have any of the following at birth: Jaundice? Y N Cyanosis? Y N

Rh incompatibility factors? Y N

Medical History

**\***Please mark if and when you have had any of the following:

\_\_\_ Seizures \_\_\_ High fevers \_\_\_ Measles \_\_\_ Mumps

\_\_\_ Chicken pox \_\_\_ Whooping cough \_\_\_ Diphtheria \_\_\_ Bronchitis

\_\_\_ Pneumonia \_\_\_ Tonsillitis \_\_\_ Meningitis \_\_\_ Encephalitis

\_\_\_ Rheumatic fever \_\_\_ Tuberculosis \_\_\_ Sinusitis \_\_\_ Chronic colds

\_\_\_ Enlarged glands \_\_\_ Thyroid \_\_\_ Asthma \_\_\_ Heart trouble

\_\_\_ Chronic Laryngitis \_\_\_ Diabetes \_\_\_ Head injuries

For items marked above, give the relevant details (e.g., how frequent and/or how severe are these episodes?):

Recurrent earaches/ear infections? Describe:

Are immunizations current? Current general health?

Allergies? (Describe)

Any other serious or recurrent illnesses? When?

Any operations? When?

Any accidents? When?

Any medications? (Past) (Current)

**\***Hearing difficulties? If so, Aided?

Vision problems? If so, treatment?

Dental problems: Treatment:

Other: Left or right handed?

Personal Medical Information

Personal Primary Physician: Date of last visit:

Address or Location:

Ongoing Medical Care (Describe):

Physician's Name: City:

Current Medications: Dosage: Physician: Location:

Chronic Health Problems (Asthma, Congenital Defects, etc.):

Handicaps (Describe, if any):

**Family**

Names and ages of children:

**\***Any speech or hearing problems in the family? Explain:

**Speech and Language**

Do you know of any concerns regarding early speech and language development?

Describe:

Other language(s) spoken in the home:

Language spoken by mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language spoken by father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had difficulty understanding or expressing yourself? Describe:

**\***What are your communication needs in social settings?

**\***What difficulty do you have meeting your communication needs?

Do you speak more than one language?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, list languages.\_\_\_\_\_\_ \_\_\_\_\_\_

**Educational History**

Schools attended:

Diplomas or degrees:

Future educational plans:

Were you or are you satisfied with your academic performance? If not, why not?

**\***How did or does your communication difficulty affect your performance in school?

**Vocational History**

**\***How have communication difficulties affected the types of jobs you have held?

**\***Describe your current job setting and your communication needs:

**\***How do communication problems affect your current job?

**\***Does your communication difficulty affect your future job plans? Explain:

**General Information**

Hobbies:

Social and/or civic groups to which you belong:

Religion:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dietary Restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many family members live in your household?\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the relation of these people to you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you celebrate holidays?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, please list here.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other information you would like us to know:

***This case history form is a modified version of the case history form used at the speech-language and hearing clinic at Brigham Young University.***