Northeastern University

Department of Communication Sciences & Disorders
Speech-Language and Hearing Center
503 Behrakis Health Science Center Boston, MA 02115
(617) 373-2492

SPEECH-LANGUAGE EVALUATION
ADULT CLIENT APPLICATION FORM

TODAY'S DATE: _____

IDENTIFYING INFORMATION:

Name of person filling out this form:		
Name of person to be evaluated if different from above:	**Sex:**	
Address:	Phone: Home _____ Cell _____ Work _____	
Email: Date of Birth:	Age:	Marital Status:
Level of Education Completed:	Occupation:	
Language Dominance:		
Other Languages Spoken:		

NAME OF SPOUSE:	Date of Birth:	Age:
Level of Education Completed:	Occupation:	

If under 21 and/or living with parents:

FATHER'S NAME:	Date of Birth:	Age:
Address:	Phone: Home _____ Cell _____ Work _____	
Level of Education Completed:	Occupation:	
MOTHER'S NAME:	Date of Birth:	Age:
Address: ☐ check here if same as above	Phone: Home _____ Cell _____ Work _____	
Level of Education Completed:	Occupation:	

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STUDENT INFORMATION (IF APPLICABLE):

Local address (if different from previous page):	
College/University:	Year:
Major:	Do you have a job while in school? ☐ Yes ☐ No

REASON FOR REFERRAL/REQUEST:

1. Who referred you?	Position:
2. Reason for referral:	
3. Do you feel you have a problem? ☐Yes ☐No	Describe:
4. When and how did the difficulty begin?	
5. Who was the first person to notice the difficulty?	
6. Was anything done about your difficulty after it was first noticed? ☐Yes ☐No	
If yes, please describe.	
7. How would you rate the severity of the problem now? ☐ Very mild ☐Mild ☐Moderate ☐Moderately severe ☐Severe	
8. Describe any changes that you have noticed in your speech problem since it began.	
9. Is the difficulty worse at some times than at others? If yes, please explain.	

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10. Please check only those characteristics that are true of your speech NOW. This will aid in preparation for your evaluation.
☐ Difficulty saying the /s/ sound or have a "lisp"
☐ Mispronounce or omit a sound or sounds while speaking
☐ Foreign or regional dialect; if checked:
☐ Where were you born?
☐ When did you move to the U.S.?
☐ When did you learn English?
☐ Did you have any difficulty in your native language? ☐ Yes ☐ No
☐ Difficulty recalling names of people, objects, etc.
☐ Difficulty speaking in complete, well-organized sentences
☐ Difficulty coordinating voice, tongue, lips, etc. to produce speech
☐ Drooling problem while talking
☐ Overly tense while talking
☐ Stuttering or stammering problem
☐ Repeat sounds, words, parts of words, or phrases regularly while talking
☐ Difficulty / pause before saying certain sounds or words
☐ Hold breath while talking
☐ Out-of-breath while talking
Voice is abnormally ☐ low-pitched ☐ high-pitched
☐ Voice sounds like it is coming through the nose
☐ Voice always sounds like I have a cold
People complain that I always talk ☐ too softly ☐ too loudly
☐ My speech seems normal
11. Please describe further the items checked above.
12. Have you had a speech and language evaluation at any other clinic? ☐ Yes ☐ No

Name of clinic:	Date of evaluation:
Address:	

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13. Have you received speech therapy previous to this time? ☐ Yes ☐ No	
When?	For how long?
Where?	Therapist's name:
Length of each session:	Sessions per week:
Focus of therapy:	

14. Please check any of the following characteristics that are true of your HEARING now:

- ☐ Hearing loss in one/both ear(s) ☐ right ☐ left
- ☐ Can hear, but not understand when people talk to me
- ☐ Prefer having the television turned louder than those around me
- ☐ Difficulty hearing in a one-to-one situation
- ☐ Difficulty hearing in groups
- ☐ Difficulty hearing on the telephone
- ☐ No difficulty hearing

15. Have you ever had a hearing test? ☐ Yes ☐ No
When? _____ Where? _____

16. Have you ever worn a hearing aid? ☐ Yes ☐ No
When? _____

17. Do you wear a hearing aid now? ☐ Yes ☐ No
If yes, approximately when was it purchased? _____
Make and Model number: _____
Hearing Aid Dealer: _____
Address: _____

18. Does the aid seem to be operating properly at this time? ☐ Yes ☐ No
If not, what seems to be the trouble? _____
_____

HEALTH RECORD:

1. Describe your general health.

2. Are you currently under medical treatment or medication? ☐ Yes ☐ No

3. Who is your family physician or ear-nose-throat (ENT) specialist?

Name: _____ Phone: _____

Address: _____

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4. List and describe any hospitalization, operations, or accidents (indicate age at time of occurrence).

_____

5. Please indicate if you have had any of the following:

☐ Mumps	☐ Convulsions	☐ Fainting spells
☐ Measles	☐ Tuberculosis	☐ Ear aches/infections
☐ Chicken pox	☐ Arthritis	☐ Pneumonia
☐ Whooping cough	☐ Frequent laryngitis	☐ Allergies
☐ Scarlet fever	☐ Tonsillitis	☐ Meningitis
☐ High fever	☐ Frequent colds	☐ Freq. sore throats
☐ Dizziness	☐ Sinus trouble	☐ Other: _____

6. Do you ever hear noises (ringing, buzzing, roaring, etc.) in your ears? ☐ Yes ☐ No

7. Have you been exposed to loud sounds (gunfire, heavy machinery, etc.)? ☐ Yes ☐ No

8. Have any other members of your family had speech and/or hearing difficulties? Please describe.

9. Does anyone in your family have a history of the following:

Problem:	**Relationship to you:**
☐ speech, language problems	
☐ hearing problems	
☐ brain damage	
☐ intellectual disability	
☐ cerebral palsy	
☐ emotional disturbance/mental illness	
☐ chronic illness type:	

10. Have you ever had a psychological, psychiatric, or neurological evaluation? ☐ Yes ☐ No

Type and date of evaluation:

Name of clinic, hospital, etc.

Address:

11. Have you ever had counseling or psychotherapy? ☐ Yes ☐ No If yes, please provide information.

Name of counselor, psychiatrist, etc.

Address:

Dates:

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May we have your permission to request information about the evaluation and/or therapy mentioned above to assist us in our evaluation of your present difficulty? ☐Yes ☐No

If yes, please fill out one of the attached "AUTHORIZATION FOR RELEASE OF INFORMATION" forms. If the evaluation and therapy took place in more than one place, please fill out one form for each setting.

Are there any limitations on your schedule that would make it impossible for you to come for an evaluation on any specific day? ☐Yes ☐No If yes, please describe: _____
_____

If you have any other information which you feel would be helpful to us in preparing for your evaluation, please write it in the space provided here.

_____

_____

Thank you for your time in filling out this form!

Please email your completed form to SLHC@northeastern.edu, or print and mail to:

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