

**Texas Tech University Health Sciences Center  
Speech-Language & Hearing Clinic  
Adult Speech-Language and Hearing History**

The information you provide in this questionnaire will help us assess your communication and/or swallowing difficulties. Please complete this form, answering questions as completely as possible. If there are any items you do not fully understand, please discuss them with the supervisor during your assessment appointment.

**IDENTIFYING INFORMATION**

Today's Date:		Birthdate:	Gender: M F	Age:
Name:		Social Security #:		
Address:				
City:		State:	Zip:	
Person Completing Form:				
Daytime Phone:		Evening Phone:		
Name of Insurance and Primary Care Physician:				
Policy #:		Is physician referral required?		

**HOME AND FAMILY INFORMATION**

Social Security Number:	Occupation:
Highest grade or degree completed:	Retired? YES NO
Languages spoken in home:	Work Phone:
Primary language:	

**ASSESSMENT CONCERNS**

What are the concerns regarding your communication, hearing, and/or swallowing skills?

**FAMILY MEMBERS (Names, Genders, and Ages)**

Name	Live at home?	Relationship	Age	Sex	List any speech, hearing, learning, or medical problems



**HEARING AND EAR HISTORY****Description**

	<b>Yes</b>	<b>No</b>	
Do you think your hearing is poor? Which ear?			
Have you ever been diagnosed with a hearing loss?			
Were hearing aids recommended?			
Have you used hearing aids?			
Are there situations in which you have difficulty hearing?			
Do you hear noises in your ears or head?			
Do you have dizziness or imbalance?			
Do you have a feeling of fullness or pain in your ears?			
Ear surgeries (ages, ear operated on, and type of surgery)			

**TESTS DONE****Where****Date****Age****Results**

	<b>Where</b>	<b>Date</b>	<b>Age</b>	<b>Results</b>
Hearing Test				
Speech/Language				
Vision Exam				
Neurological				
Brain CT Scan or MRI				
Psychological				

**FAMILY HISTORY****Description (relationship and type of problem)**

<i>Ex: Speech Problems: Uncle who stutters; Learning Problems: Mother who has ADHD</i>	
Neurologic Diseases	
Speech Problems	
Learning Problems	
Hereditary Illnesses	
Ear/Hearing Problems	

**SPEECH/LANGUAGE PROBLEMS (If not, skip this portion.)**

Please describe your communication problem(s).
What do you think caused or is causing the communication problem(s).
Have you received speech-language therapy in the past? Yes/No If so, please tell us when and for what.

**SWALLOWING PROBLEMS****(If not, skip this portion.)****Yes****No****Describe**

Do you have pain or difficulty swallowing?			
Have you seen a doctor about your swallowing?			
Do you have difficulties feeding yourself?			
Is there a texture of food that is easiest to swallow?			
Is there a texture of food that is difficult to swallow?			
Is there a temperature of food that is easiest to swallow?			
How did the swallowing problem begin? (circle one)	Gradually	Suddenly	Intermittently
What do you feel caused the swallowing problem?			
How long does it take you to eat a meal?	At what time do you eat your last meal or snack?		
How many meals to you have daily?			
Has your swallowing problem changed or limited your lifestyle? Yes / No. If yes, please describe.			

**VOICE PROBLEMS (If not, skip this portion.)****Yes****No****Sometimes****Describe**

Do you have a voice problem(s)?				
Have you seen a doctor for your voice problem(s)?				
Have you had hoarseness lasting longer than 1 week?				
Do you have tension in your neck muscles?				
Do you have difficulty maintaining a loud voice?				
Do you have a feeling of a lump in your throat?				
Do you have pain or burning at the back of your throat?				
Do you have frequent sore throats?				
Do you feel the need to clear your throat often?				
Do you have excessive coughing?				
Do you feel that talking is effortful?				
Does your voice become tired after lengthy talking?				
Do you have pain in your neck muscles?				
Do you have shortness of breath while speaking/singing?				
Do you have problems with dry throat and/or mouth?				
Do you have a scratchy throat?				
When is your voice best? (circle)	Early morning	Afternoon	Evening	Night
When is your voice worst? (circle)	Early morning	Afternoon	Evening	Night
What do you think caused your voice problem(s)?				
Were there any conditions surrounding the onset of your voice problem? (cold, illness, surgery, personal problems)				

<b>PERSONAL/LIFESTYLE</b>	<b>Yes</b>	<b>No</b>	<b>Additional Questions</b>
Do you currently smoke?			If yes, ____ packs per day for ____ years
Have you ever smoked?			If yes, when did you stop? _____
Do you consume alcohol?			If yes, how much per week? _____
Do you consume caffeinated coffee or tea?			If yes, how much per day? _____
Do you consume caffeinated soda?			If yes, how much per day? _____

Please add anything else you feel would be helpful in assessing your speech, language, voice, and/or swallowing problems.

*Thank you for your time and effort filling out this questionnaire. Please mail or fax this document to:*

**Speech-Language & Hearing Clinic  
 Texas Tech University Health Sciences Center  
 3601 4th Street - Stop 6073  
 Lubbock, Texas 79430-6073  
 Fax: (806) 743-5670**

Signature \_\_\_\_\_