

ADULT APPLICATION FOR LANGUAGE/SPEECH EVALUATION



Western Michigan University Unified Clinics
Charles Van Riper Language, Speech, and Hearing Clinic
1000 Oakland Drive | Kalamazoo, MI 49008 | (269) 387-7059

GENERAL INFORMATION

Name _____ Date of Birth _____ Age _____

Gender Male Female Transgender

Address _____ Phone _____

Marital Status _____ Spouse's Name _____ Information given by _____

REFERRAL AND INSURANCE INFORMATION

Referred by (name and address): _____

Reason for referral: Therapy Consultation Recommendations Other

If Other, please specify: _____

List the agencies or specialists who have seen you/your client.

Agency / Specialist	Address	Date of Examination
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Health Services Insurance Information (Check all that apply):

Medicaid Other Insurance

If Other, please specify:

HEALTH HISTORY

1. Describe your present general health: _____

2. Do you have any other serious illnesses or diseases?

3. When did the communication problem begin? _____

How did it arise? _____

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4. Do you have any allergies? Yes No

a. If yes, what allergies? _____

5. Are there any vision problems? Yes No Do you wear glasses? Yes No

6. Do you walk independently? Yes No

Do you use a cane, walker or wheelchair? Yes No

7. Are there any special considerations we need to know about regarding your safety in our clinic? (for example: seizures, risk of falling, other)

8. Please list all prescription and over the counter medications used regularly:

SPEECH AND LANGUAGE HISTORY

1. What is your native language? _____

2. Do you use a language other than English? _____

3. Please tell us about any prior speech-language treatment:

Dates: _____ Location _____ Therapist _____

Dates: _____ Location _____ Therapist _____

Dates: _____ Location _____ Therapist _____

SPEECH AND LANGUAGE INTERVENTION HISTORY

Have you had previous speech therapy? Yes No If yes, when? _____

If yes, where? _____ Therapy provided by whom? _____

Please describe the results / recommendations: _____

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HEARING STATUS

Do you have a hearing problem? Yes No Describe: _____

Have you had a hearing exam recently? Yes No If yes, when? _____

Who performed the exam? _____

Please describe the results: _____

Do you wear hearing aids? Yes No

PSYCHO-SOCIAL HISTORY

1. Who is your immediate family _____

Who is the primary caregiver? _____

2. Please tell us about your occupational and/or work history: _____

3. Please tell us about your education: Highest level of education achieved _____

Special Training: _____

4. Tell us what you like to do for enjoyment, hobbies, and leisure time: _____

5. Are there any other unique qualities or accomplishments that you would like us to know?

6. What do you feel is your speech and language problem? _____

7. How do you feel you are adjusting to the speech and language problems? _____

8. How do you feel about your speech and language problems? _____

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STATEMENT OF THE PROBLEM

Please describe the communication problem in your own words (give examples).

Please describe the reactions of others (parents, relatives, friends, etc.) to your speech or language.

What do you expect to have answered during your visit to the Charles Van Riper Language, Speech, and Hearing Clinic?

Signature of person completing this form: _____

Relationship to client: _____

Date: _____