

PROVIDENCE SPEECH AND HEARING CENTER
1301 PROVIDENCE AVENUE
ORANGE, CA 92868

CONFIDENTIAL ADULT QUESTIONNAIRE

I. GENERAL INFORMATION

Name: _____ DOB: _____

Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____ In case of emergency,

contact: _____ Relationship: _____ Phone: (____) _____

Place of birth: _____ Email address: _____

Marital Status: _____ Language(s) spoken: _____

Spouse Name: _____

Children / Other individuals living in the home (number): _____ Names & ages: _____

Who do you rely on for emotional support?: _____

Please describe the reason for your visit: _____

When was the problem first noted and has it caused emotional, family or occupational difficulties?: _____

Who should we contact to ask questions? Name(s) _____

_____ Relationship: _____ Phone: (____) _____

OTHER EVALUATIONS: (IMPORTANT!)

TYPE	DATE	LOCATION	RESULTS

IMPORTANT!! – YOU MUST INCLUDE REPORTS FOR ABOVE MENTIONED EVALUATIONS.

II. MEDICAL HISTORY

Have you been recently hospitalized? YES NO If so, where and when? _____
IMPORTANT! SEND IN HOSPITAL DISCHARGE REPORTS WITH THIS QUESTIONNAIRE

Primary Care Physician Name: _____

Address: _____ Phone: (____) _____

Other specialists: _____

Address: _____ Phone: (____) _____

Address: _____ Phone: (____) _____

Please answer with a "yes" or "no" if you have experience any of the following. For "yes" answers, please specify when it was first discovered.

Hypertension _____ Heart Disease/Attack _____

Stroke _____ Diabetes _____

Smoking _____ Drug use _____

GERD/LPR/Reflux _____ Asthma or Allergies _____

Voice Problems _____ Swallow problems _____

Traumatic injury _____ Neurological disease _____

Hearing Loss _____ Hearing aid(s) worn _____

Cerebral Palsy _____ Seizures _____

Paralysis/Weakness of the face, tongue, vocal cords or other extremities _____

Other illnesses or problems not mentioned above _____

Surgeries which may be relevant to your visit _____

CT scan, EEG, MRI _____ Reason: _____

Other procedures not mentioned above _____

KNOWN FAMILY HISTORY: Answer "yes"/"no". Specify who (e.g. aunt) and type where applicable.

Hearing problems _____ Bone problems _____

Cleft palate _____ Speech/ Language Disorder _____

Cerebral Palsy _____ Seizure Disorder _____

Neurological disease _____ Psychological Disorder _____

Reflux/GERD _____ Autism/ Developmental Disorder _____

Parkinson or Alzheimer Disease _____ Voice Problems _____

Please check which of the following is accurate:

Left handed _____ Right handed _____ Use both hands equally well _____

III. EDUCATIONAL HISTORY

Institution(s) attended: _____

Diploma or degrees (type) obtained: _____

List activities you enjoy: _____

Are you involved with any of the following agencies? If so, how long:

Social security SSI disability _____ Counseling _____

Home health _____ Rehabilitation _____

Other: _____

IV. OCCUPATIONAL STATUS

Kinds of work done: _____

Longest employment: _____

Date of last employment: _____

Employer: _____

Type of work: _____

Amount of communication proficiency required: _____

List any employment difficulties: _____

IV. ADDITIONAL COMMENTS

On a separate sheet of paper, please send further explanation of how we may assist you, further medical history information, dates, etc. Please contact us if you have questions (714) 639-4990.

Signature of person completing form Relationship

Date