

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

CONFIDENTIAL ADULT QUESTIONNAIRE

I. GENERAL INFORMATION

Name: _____ DOB: _____

Address: _____

City/State/Zip: _____ Phone: (____) _____

In case of emergency, contact: _____ Phone: (____) _____

Place of birth: _____

Marital Status: _____ Length of Marriage: _____

Name and age of spouse: _____

Individuals living in the home (number): _____

Names and ages: _____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

Who do you rely on for emotional support?: _____

Second language spoken: _____

Nature of your communication problem and when it was first noted: _____

Has this communication problem caused emotional, family or occupational difficulties?: _____

Other evaluation: Type: _____

Where: _____

Dates: _____

Emergency Contact: _____ Phone: (____) _____

II. MEDICAL HISTORY

Medical Specialist: _____

Address: _____ Phone: (____) _____

Please answer with a “yes” or “no” if you presently have or have ever had any of the following:

Hypertension _____

Heart Disease _____

Stroke _____

Diabetes _____

Other _____

Traumatic injuries to the ear, eardrum, or related structures _____

Chronic ear disease _____

Hearing Loss _____

Hearing aid worn _____ Right _____ Left _____

Acute or chronic infection of the brain or spinal cord _____

Neurological disease _____

CT scan or EEG _____ Reason: _____

Cerebral Palsy _____

Head injury with loss of consciousness _____

Paralysis of the face, tongue, vocal cords or extremities _____

Seizures _____

Surgery involving the brain, heart, eardrum, mastoid, palate or tongue _____

Family history of:

Hereditary deafness _____

Otosclerosis _____

Cleft Palate _____

Language Disorder _____

Cerebral Palsy _____

Neurological disease _____

Please check the following where applicable:

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

III. EDUCATIONAL HISTORY

Institutions attended: _____

Diplomas or degree: _____

List leisure activities: _____

Are you involved with any of the following agencies:

Vocational rehabilitations _____

Social security ssi disability _____

Mental health/Counseling _____

Home health _____

Other: _____

Name of counselor at above agency: _____

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

In the space provided below, please explain those questions that you answered with a “yes”. Indicate dates, treatment, duration, and current status. Use this space for any other comments pertaining to your medical history.

Signature of person completing form

Relationship

Date