HSDC
Hearing, Speech & Deaf Center

SPEECH, LANGUAGE & COMMUNICATION
ADULT HISTORY FORM

Client's Name________________________________ Today's Date ____________________________

Date of Birth______________ Sex/Gender ______________ Pronouns ______________________

Person Filling out Form _______________________ Relationship to Client__________________

Client's Occupation____

Client's Educational Background____

Client's Primary Language____

1. Please indicate what your specific concern(s) is/are: (*please check*)

☐ Speech Articulation ☐ Head Injury ☐ Chewing ☐ Voice

☐ Stuttering ☐ Stroke ☐ Swallowing ☐ Other

☐ Expressing Yourself ☐ Problem Solving ☐ Dentition

☐ Understanding Others ☐ Memory Loss ☐ Tongue Thrust

☐ Reading/Writing ☐ Hearing Loss ☐ Head/Trunk Muscle Weakness

Please describe your concerns

____

____

____

2. How long have you had this concern?

____

____

____

3. What questions would you like answered at your appointment?

4. Describe how your specific concerns affect you in your daily life:

5. Have you had any speech therapy or other intervention in the past? If so, when?

What areas of difficulty were addressed in therapy?

Name of therapist______________________ | Phone number_________________________

6. Do any of your family members have a history of speech, language, hearing, or learning difficulties? If so, please describe:

7. Do you use a nonverbal form of communication? If so, please describe:

8. Medical History

a. Please indicate whether you have experienced any of the following: (*please check*)

- ☐ Allergies
- ☐ Seizures
- ☐ Upper Respiratory Infection
- ☐ Asthma
- ☐ Noise Exposure
- ☐ Reflux
- ☐ Pneumonia
- ☐ Dental Problems
- ☐ Enlarged Adenoids
- ☐ Ear Infections
- ☐ Neurological Problems

b. Other illnesses:

c. Please list any significant injuries you have suffered and the dates on which they occurred:

d. Please list any significant surgeries you have had and the dates on which they occurred:

e. Please list any medications you are currently taking:

Complete the following section only if you are experiencing difficulty with your voice

1. Describe the feelings you are experiencing in your throat: (*please check*)

☐ Hoarseness	☐ Loss of Voice	☐ Pain
☐ Difficulty Swallowing	☐ Difficulty Singing	☐ Strain
☐ Fatigue	☐ Tickling Sensation	☐ Other________________

2. Do you:

-smoke?	☐ Yes	☐ No	How often?__________
-drink caffeinated products?	☐ Yes	☐ No	How often?__________
-sing?	☐ Yes	☐ No	How often?__________
-engage in activities that require a loud voice or yelling (e.g., acting, public speaking, teaching, cheering at sporting events)?	☐ Yes	☐ No	List activities:

Complete the following section only if you are experiencing difficulties with stuttering

1. Describe the nature of your stuttering (e.g. repeating, getting stuck):

2. Do you avoid certain speaking situations? If so, please describe:

3. Are there times when your stuttering is better or worse?

MEDICAL INFORMATION AND CONSENT FOR MEDICAL TREATMENT

MEDICAL INFORMATION

Client Name: ______________________________
Address: ______________________________
Emergency Phone: ______________________________
Primary Care Provider: ______________________________
Health Insurance: ______________________________
Medications: ______________________________
Allergies: ______________________________
Other Relevant Medical Information: ______________________________
____

EMERGENCY CONTACT PERSON

Person who will be nearby or most reachable in the event of an emergency.

Name: ______________________ Relation to Client: ______________________
Phone: ______________________ Language: ______________________
Email Address: ______________________

CONSENT FOR MEDICAL TREATMENT

I hereby appoint the staff of HSDC to act on my behalf in authorizing or providing emergency treatment to include: first aid and CPR; contacting 9-1-1; diagnostic procedures; medical, surgical, and hospital care; or treatment procedures to be performed for myself or my dependent by a licensed physician, hospital, or emergency personnel when deemed necessary and advisable by the physician to safeguard my or my dependent's health. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment. I also give permission for myself or my dependent to be transported by ambulance or aid car to an emergency center for treatment. I do not hold Hearing, Speech & Deaf Center responsible for any emergency treatment that may be administered. I acknowledge that I am responsible for all charges in connection with care and treatment. This consent is effective for the duration of my or my dependent's plan of care.

______________________________ ______________
Printed name of client or personal representative Date

______________________________ ______________
Signature of client or personal representative* Date
* Required if client is younger than 18 years of age at time of first appointment

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: ____ Date of Birth:_____________________
Today's Date: _____________________

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your individually identifiable health information without your authorization, except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

I Authorize the Release Of:

☐ **ALL** my health information maintained ☐ Include Previous Provider Records

☐ My health information relating to the following treatment or condition:
____

☐ My health information for the date(s):_________________ ☐Other: ___________________________

Reason For Release (must be noted): ____
Send/Release Medical Records To:

Name:____ Name:____
Phone: ____ Phone: ____
Address:____ Address:____
Fax: ____ Fax: ____

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE Check ALL Requested Exclusions: ☐Alcohol/Drug ☐Behavior/Mental Health/Psychiatric ☐Sexually Transmitted Disease ☐HIV/AIDS ☐Other; specify exclusion _________________________

I understand that I have the right to request that a service for which I have paid out-of-pocket, not be disclosed to my health plan.
This Authorization is Effective: **Date** **through** (dates must be specified)

____ ____
Printed name of client or personal representative Signature of client or personal representative*
Required if client is younger than 18 years of age at time of first appointment

REFUSAL TO SIGN AUTHORIZATION: I understand that by declining to sign this form, my medical (healthcare) treatment and insurance benefits will not be affected, however, my medical records CANNOT be released. I understand that I may revoke this authorization at any time by notifying the organization in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

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(206) 323–5770 | Toll-Free: (888) 222–5036 | Videophone: (206) 452–7953

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POLICIES AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT

Client Name: ____ Date of Birth: ___________________
Today's Date: ________________

GENERAL CLINIC PROCEDURES & ATTENDANC POLICY

_____ *(please initial)* I acknowledge that I have read and understand the general clinic procedures and attendance policy.

FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

_____ I acknowledge that I have read and consent to the financial responsibility disclosure statement.

NOTICE OF PRIVACY PRACTICES

_____ I acknowledge that I received a copy of Hearing, Speech & Deaf Center's Notice of Privacy Practices. The Notice provides information about how HSDC may use and disclose the medical information that we maintain about you. HSDC encourages you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website, and that any revised Notice of Privacy Practices will be made available.

CONSENT TO THE USE OF VIRTUAL/REMOTE SERVICES

_____ I have read and understand the information provided regarding virtual/remote services in the *General Clinic Procedures* document. I hereby consent to and authorize HSDC to use distance technology to provide virtual or remote services to supplement the in-person services provided by HSDC.

PHOTO/PUBLICATIONS RELEASE

_____ I give HSDC or its legal representatives the absolute right and permission to include my name in articles, and to copyright and/or publish photographic portraits, pictures, or videos of me, and to use my photo in conjunction with a fictitious name for art, health, education, marketing, or any other lawful purpose. I waive my right to inspect and/or approve the finished product or the use to which it may be applied. I release, discharge, and agree to hold harmless HSDC or its legal representatives from any liability by virtue of any blurring, alteration, optical illusion, or use in composite form whether intention or otherwise, that may occur or be produced in the taking of said pictures or any processing tending towards the completion of the product.

My signature below, indicates that I have read, understand, and agree with the items I initialed above.

______________________________________ ______________________________________
Printed name of client or personal representative Signature of client or personal representative*
**Required if client is younger than 18 years of age at time of first appointment*