HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
hsdc.org

SPEECH, LANGUAGE & COMMUNICATION
ADULT HISTORY FORM

Client's Name_____ Today's Date_____
Date of Birth_____
Name of person completing this form (if different than client)_____
Client's Occupation_____
Client's Educational Background_____
Client's Primary Language_____
Client's Primary Care Physician_____

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

- ☐ Speech Articulation
- ☐ Stuttering
- ☐ Expressing Yourself
- ☐ Understanding Others
- ☐ Reading/Writing/Math
- ☐ Head Injury
- ☐ Stroke
- ☐ Problem Solving
- ☐ Memory Loss
- ☐ Hearing Loss
- ☐ Chewing
- ☐ Swallowing
- ☐ Dentition
- ☐ Tongue Thrust
- ☐ Head/Trunk Muscle Weakness
- ☐ Voice
- ☐ Other

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:

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
hsdc.org

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:

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
hsdc.org

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 caffeine 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?

THANK YOU!

HSDC
Hearing, Speech & Deaf Center

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: _____
_____
_____

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 child by a licensed physician, hospital, or emergency personnel when deemed necessary and advisable by the physician to safeguard my or my child'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 to be transported by ambulance or aid car to an emergency center for treatment. I do not hold Hearing, Speech & Deafness 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 child's therapy program.

Client Name: _____

Parent/Guardian Name (if client is under 18): _____

Signature: _____ Date: _____

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I request and authorize Hearing, Speech & Deaf Center to release, obtain, exchange healthcare information on:

Client Name: _____ **DOB:** _____

___ I consent to Hearing, Speech & Deaf Center releasing protected health information as detailed below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

MY PROTECTED HEALTH INFORMATION MAY BE USED OR DISCLOSED TO THE FOLLOWING (e.g., doctor, school, other related service providers):

Name:_____
Facility: _____ Phone: _____
Address:_____ Fax:_____

Name:_____
Facility: _____ Phone: _____
Address:_____ Fax:_____

SPECIFIC INFORMATION to be Released/Obtained/ Exchanged:

___Speech/Language ___Parent-Infant ___Educational ___Psychiatric Reports
____Audiology ___Medical ___Other

SIGNATURE By signing, I understand that:

- I have the right to request restrictions as to how my protected health information may be used or disclosed.
- I authorize HSDC to release any information required to insurance companies, medical providers, and others as required by law or court order.
- This authorization is in effect until written notice of revocation to the address listed at the top of this form is received. I may revoke this authorization at any time, except to the extent that action has already been taken based on this authorization.
- Authorizing the disclosure of this health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.
- If I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____
Signature of patient or personal representative Printed name

_____ _____
Relationship to client or patient Date

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

CLIENT ENROLLMENT & EMERGENCY CONTACT FORM

This contract is to *(check one)* ☐ Enroll ☐ Renew Enrollment for HSDC services for:

Client's Name_____ Date of Birth_____

Parent/Guardian Names Other Language(s):

_____ ☐ Deaf ☐ Hearing ☐ Hard of Hearing _____

_____ ☐ Deaf ☐ Hearing ☐ Hard of Hearing _____

EMERGENCY CONTACT PERSONS

Primary Contact: person who will be nearby or most reachable in the event of an emergency.

Name_____ Relation to Client_____

☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Other Language(s)_____

Home Phone_____ *(please check)* ☐ Voice ☐ TTY ☐ Videophone

Work Phone_____ *(please check)* ☐ Voice ☐ TTY ☐ Videophone

Cell Phone_____ *(please check)* ☐ Voice ☐ Text

Home Address_____ Email Address_____

Secondary Contact: person we should try next in the event of an emergency.

Name_____ Relation to Client_____

☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Other Language(s)_____

Home Phone_____ *(please check)* ☐ Voice ☐ TTY ☐ Videophone

Work Phone_____ *(please check)* ☐ Voice ☐ TTY ☐ Videophone

Cell Phone_____ *(please check)* ☐ Voice ☐ Text

Home Address_____ Email Address_____

OTHER INDIVIDUAL AUTHORIZED TO PICK UP THE CHILD FROM HSDC

Name_____ Relation to Client_____

☐ Deaf ☐ Hearing ☐ Hard of Hearing ☐ Other Language(s)_____

Home Phone_____ *(please check)* ☐ Voice ☐ TTY ☐ Videophone

Work Phone_____ *(please check)* ☐ Voice ☐ TTY ☐ Videophone

Cell Phone_____ *(please check)* ☐ Voice ☐ Text

Home Address_____ Email Address_____

Is it OK to leave voicemail containing confidential healthcare information with the numbers provided? ☐ Yes ☐ No

PHOTO/PUBLICATIONS RELEASE (OPTIONAL)

I give HSDC or its legal representatives the absolute right and permission to include my child's name in articles, and to copyright and/or publish photographic portraits, pictures, or video of my child, and to use my child's 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.

Client/Parent/Guardian Name _____Client/Parent/Guardian Signature_____

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

HSDC is a teaching facility. Students may observe, participate in, or administer treatment plans developed by your licensed clinician. If you have concerns, please consult the director.

HSDC staff are mandated reporters and are required to report suspected abuse or neglect of minors in accordance with RCW 26.44.030.