SOUTHEAST MISSOURI
STATE UNIVERSITY · 1873

Center for Speech and Hearing
Southeast Missouri State University
One University Plaza, Cape Girardeau, Missouri 63701-4799
(573) 651-2050 * FAX (573) 651-2827

Speech-Language Pathology Adult Pre-Evaluation Questionnaire

Note: In order to give you the best service and to keep the time spent in evaluation at a minimum, we ask you to provide us with the information below. Please return this questionnaire to us AS SOON AS POSSIBLE. Also please forward any additional copies of tests administered elsewhere or other information that you feel might be of help to us.

Date: _____

Client's ☐ Male

Name: _____ Birthdate: _____ Age: _____ ☐ Female

Name of person answering questionnaire: _____ Relationship to Client: _____

Is this individual a Medicare beneficiary? ☐ Yes* ☐ No

*If yes: please note that we are unable to provide Medicare beneficiaries with traditional clinical services at this time. However, the Department of Communication Disorders does conduct intervention research for individuals across the life span. Please check the box if you would might be interested in participating in a research study, and we will contact you with additional information to see if you would qualify.

☐ I would be interested in being contacted for participation in a department research project.

Has this individual been seen in this clinic in the past? ☐ Yes ☐ No If yes, when? _____

Client's Address: _____ Telephone: _____

_____ Email address: _____

_____ Occupation _____

Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced Language(s) spoken: _____

Spouse/Significant Other's Name: _____ Telephone: _____

Address: _____ Email address:_____

Emergency Contact Name and Telephone: _____
Name *Telephone*

Referred by: _____

CONCERN: Describe your speech or language concern.

_____

_____

_____

_____

When, how and by whom were the concerns first noticed:

_____

EDUCATION:

Level of education: □ Elementary □ Two-year degree □ Other _____
□ High School □ Four-year degree
□ Some college □ Graduate _____

Reason for stopping (if applicable):
_____

What were your usual grades:
_____

With what subjects did you have particular difficulty?
_____

_____

MEDICAL INFORMATION:

Are you in good health at this time? ☐ Yes ☐ No
In no, please specify: _____

Do you have difficulty in chewing or swallowing? ☐ Yes ☐ No
Do you have a visual problem? ☐ Yes ☐ No If yes, describe: _____
Do you wear eyeglasses? ☐ for reading ☐ for distance ☐ most of the time ☐ no
Do you have a hearing problem? If yes, describe: _____
Have you had a hearing test prior to this time? ☐ Yes ☐ No

If yes, where? _____
Name of Audiologist *Address* *Telephone*
Have you had a neurological examination? ☐ Yes ☐ No
If yes, where? _____
Name of hospital/clinic and physician *Address* *Telephone*

What efforts have been made to help you communicate? _____

_____

Has there been a change in your speech in the last six months? ☐ Yes ☐ No
Describe your speech/language skills prior to this time: _____

_____

Do you currently or have you in the past used any of the following:
Cigarettes ☐ Yes ☐ No Pipe Tobacco ☐ Yes ☐ No Chewing Tobacco ☐ Yes ☐ No
Cigars ☐ Yes ☐ No Medications other than those prescribed for an illness or injury ☐ Yes ☐ No

Are you currently taking any medications: ☐ Yes ☐ No If yes, please list below: Use other side of form, if necessary.

Name of Medication	Dosage	Reason	Side Effects (if any)

Have you had any of the following? If so, please check below and indicate age and any complications:

Illness	Age	Complications	Illness	Age	Complications
Diptheria			Parkinson's disease		
Food Allergies		Specify:	Tonsillitis		
Mumps			Tuberculosis		
Respiratory allergies		Specify:	Bronchitis		
Scarlet Fever			Ear Infections		
Hypothyroidism			Goiter		
Heart Disease			Paralysis		
Seizures			Mental Health diagnosis		Specify:
Asthma			Frequent Colds		
Oral or Pharyngeal Cancer			Stroke		
Laryngeal Cancer			Vocal Nodules		
Vocal polyps			Other		

WORK HISTORY:

Describe/list your work history. Indicate dates of employment, type of work, etc. Please use the back side of the form, if necessary:

_____

_____

Are you still employed? ☐ Yes ☐ No If yes, where: _____

Principle duties: _____

I authorize the Southeast Missouri State University Center for Speech and Hearing to provide assessment and/or treatment in the area of speech-language-hearing disorders to _____. I understand that students enrolled in the Dept. of Communication Disorders will be involved in the evaluation and treatment, and that these students will be supervised by the Speech-Language Pathologists. Students and faculty may observe portions of the evaluation and therapy sessions, and recording may be made during sessions for the purpose of student training.

Authorized: _____ Date: _____

Regarding: _____ Date: _____