



Northeastern University

Department of Communication Sciences & Disorders
Speech-Language and Hearing Center
503 Behrakis Health Science Center Boston, MA 02115
(617) 373-2492

SPEECH-LANGUAGE EVALUATION ADULT CLIENT APPLICATION FORM

TODAY'S DATE: _____

IDENTIFYING INFORMATION:

Name of person filling out this form:		
Name of person to be evaluated if different from above:		Sex:
Address:	Phone: Home _____ Cell _____ Work _____	
Email:	Age:	Marital Status:
Date of Birth:		
Level of Education Completed:	Occupation:	
Language Dominance:		
Other Languages Spoken:		

NAME OF SPOUSE:	Date of Birth:	Age:
Level of Education Completed:	Occupation:	

If under 21 and/or living with parents:

FATHER'S NAME:	Date of Birth:	Age:
Address:	Phone: Home _____ Cell _____ Work _____	
Level of Education Completed:	Occupation:	
MOTHER'S NAME:	Date of Birth:	Age:
Address: <input type="checkbox"/> check here if same as above	Phone: Home _____ Cell _____ Work _____	
Level of Education Completed:	Occupation:	



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STUDENT INFORMATION (IF APPLICABLE):

Local address (if different from previous page):	
College/University:	Year:
Major:	Do you have a job while in school? <input type="checkbox"/> Yes <input type="checkbox"/> No

REASON FOR REFERRAL/REQUEST:

1. Who referred you?	Position:
2. Reason for referral:	
3. Do you feel you have a problem? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
4. When and how did the difficulty begin?	
5. Who was the first person to notice the difficulty?	
6. Was anything done about your difficulty after it was first noticed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe.	
7. How would you rate the severity of the problem now? <input type="checkbox"/> Very mild <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately severe <input type="checkbox"/> Severe	
8. Describe any changes that you have noticed in your speech problem since it began.	
9. Is the difficulty worse at some times than at others? If yes, please explain.	



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10. Please check only those characteristics that are true of your speech NOW. This will aid in preparation for your evaluation.	
<input type="checkbox"/> Difficulty saying the /s/ sound or have a "lisp"	
<input type="checkbox"/> Mispronounce or omit a sound or sounds while speaking	
<input type="checkbox"/> Foreign or regional dialect; if checked:	
<input type="checkbox"/> Where were you born?	
<input type="checkbox"/> When did you move to the U.S.?	
<input type="checkbox"/> When did you learn English?	
<input type="checkbox"/> Did you have any difficulty in your native language? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Difficulty recalling names of people, objects, etc.	
<input type="checkbox"/> Difficulty speaking in complete, well-organized sentences	
<input type="checkbox"/> Difficulty coordinating voice, tongue, lips, etc. to produce speech	
<input type="checkbox"/> Drooling problem while talking	
<input type="checkbox"/> Overly tense while talking	
<input type="checkbox"/> Stuttering or stammering problem	
<input type="checkbox"/> Repeat sounds, words, parts of words, or phrases regularly while talking	
<input type="checkbox"/> Difficulty / pause before saying certain sounds or words	
<input type="checkbox"/> Hold breath while talking	
<input type="checkbox"/> Out-of-breath while talking	
Voice is abnormally <input type="checkbox"/> low-pitched <input type="checkbox"/> high-pitched	
<input type="checkbox"/> Voice sounds like it is coming through the nose	
<input type="checkbox"/> Voice always sounds like I have a cold	
People complain that I always talk <input type="checkbox"/> too softly <input type="checkbox"/> too loudly	
<input type="checkbox"/> My speech seems normal	
11. Please describe further the items checked above.	
12. Have you had a speech and language evaluation at any other clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of clinic:	Date of evaluation:
Address:	



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13. Have you received speech therapy previous to this time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When?	For how long?
Where?	Therapist's name:
Length of each session:	Sessions per week:
Focus of therapy:	
14. Please check any of the following characteristics that are true of your HEARING now:	
<input type="checkbox"/> Hearing loss in one/both ear(s) <input type="checkbox"/> right <input type="checkbox"/> left	
<input type="checkbox"/> Can hear, but not understand when people talk to me	
<input type="checkbox"/> Prefer having the television turned louder than those around me	
<input type="checkbox"/> Difficulty hearing in a one-to-one situation	
<input type="checkbox"/> Difficulty hearing in groups	
<input type="checkbox"/> Difficulty hearing on the telephone	
<input type="checkbox"/> No difficulty hearing	
15. Have you ever had a hearing test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When? _____	Where? _____
16. Have you ever worn a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When? _____	
17. Do you wear a hearing aid now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, approximately when was it purchased? _____	
Make and Model number: _____	
Hearing Aid Dealer: _____	
Address: _____	
18. Does the aid seem to be operating properly at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, what seems to be the trouble? _____	

HEALTH RECORD:

1. Describe your general health.
2. Are you currently under medical treatment or medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Who is your family physician or ear-nose-throat (ENT) specialist?
Name: _____ Phone: _____
Address: _____



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4. List and describe any hospitalization, operations, or accidents (indicate age at time of occurrence).

5. Please indicate if you have had any of the following:		
<input type="checkbox"/> Mumps	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ear aches/infections
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Frequent laryngitis	<input type="checkbox"/> Allergies
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Meningitis
<input type="checkbox"/> High fever	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Freq. sore throats
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Other: _____

6. Do you ever hear noises (ringing, buzzing, roaring, etc.) in your ears? Yes No

7. Have you been exposed to loud sounds (gunfire, heavy machinery, etc.)? Yes No

8. Have any other members of your family had speech and/or hearing difficulties? Please describe.

9. Does anyone in your family have a history of the following:	
Problem:	Relationship to you:
<input type="checkbox"/> speech, language problems	
<input type="checkbox"/> hearing problems	
<input type="checkbox"/> brain damage	
<input type="checkbox"/> intellectual disability	
<input type="checkbox"/> cerebral palsy	
<input type="checkbox"/> emotional disturbance/mental illness	
<input type="checkbox"/> chronic illness type:	

10. Have you ever had a psychological, psychiatric, or neurological evaluation? Yes No

Type and date of evaluation:

Name of clinic, hospital, etc.

Address:

11. Have you ever had counseling or psychotherapy? Yes No If yes, please provide information.

Name of counselor, psychiatrist, etc.

Address:

Dates:



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May we have your permission to request information about the evaluation and/or therapy mentioned above to assist us in our evaluation of your present difficulty? Yes No

If yes, please fill out one of the attached "AUTHORIZATION FOR RELEASE OF INFORMATION" forms. If the evaluation and therapy took place in more than one place, please fill out one form for each setting.

Are there any limitations on your schedule that would make it impossible for you to come for an evaluation on any specific day? Yes No If yes, please describe: _____

If you have any other information which you feel would be helpful to us in preparing for your evaluation, please write it in the space provided here.

Thank you for your time in filling out this form.