

**Adult- AUDIOLOGY CASE HISTORY FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other language(s) spoken in the home \_\_\_\_\_\_\_\_\_\_\_

Race  White  Asian  African American  American Indian or Alaska Native   
  Native Hawaiian or other Pacific Islander  Other  Prefer not to report

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Prefer not to report

Have you been seen at this facility previously? \_\_\_\_\_\_\_\_\_ Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Problem**

1. What is your primary concern about your ears or hearing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What do you think caused your hearing problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. If you have difficulty hearing or understanding, how long have you noticed this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Which is your better ear (if they are different): Left \_\_\_\_\_ Right \_\_\_\_\_
5. Do you have difficulty understanding: TV: Yes\_\_\_\_\_ No\_\_\_\_\_Telephone: Yes\_\_\_\_\_ No\_\_\_\_\_

In groups: Yes \_\_\_\_\_No\_\_\_\_\_ In noisy rooms: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

1. How important is it for you to improve how you hear, understand, or communicate with others RIGHT NOW (mark on the line)

10 (Extremely important)

0 (Not at all important)

**History**

1. Have you had your hearing tested before? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, when and where?:

2. Any drainage from the ear within the past 90 days? Yes\_\_\_\_\_ No\_\_\_\_\_

**\*\*\*TURN OVER TO BACK PAGE\*\*\***

3. Have you experienced any dizziness, balance problems, or falls? Yes\_\_\_\_\_ No\_\_\_\_\_

4. Have you had any pain in your ears within the past 90 days: Yes\_\_\_\_\_No\_\_\_\_\_

5. Have you ever lost hearing in one ear *suddenly*? Yes\_\_\_\_\_ No\_\_\_\_\_

1. Do you have any noises or ringing in your ears? Yes\_\_\_\_\_ No\_\_\_\_\_ left/right/both

If present, is it: Constant \_\_\_\_\_ Intermittent \_\_\_\_\_

When did you first notice it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you received any medical or surgical treatment for hearing loss? Yes\_\_\_\_\_No\_\_\_\_\_
2. Have you ever been exposed to loud noise? Military Occupation/Job Recreational

If yes, describe the type of noise:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you use ear plugs/muffs consistently? Yes\_\_\_\_\_ No\_\_\_\_\_

1. Is there a history of hearing loss in your parents or siblings? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Medical problems (check all that apply):

Infectious disease \_\_\_\_\_Diabetes \_\_\_\_\_ Heart problems \_\_\_\_\_ Head injury \_\_\_\_\_

High blood pressure \_\_\_\_\_ Kidney problems \_\_\_\_\_ Vision problems \_\_\_\_\_\_\_\_\_\_

Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. In what situations would you most like help hearing?

Conversations with family or friends \_\_\_\_\_ TV \_\_\_\_\_ Telephone \_\_\_\_\_

In the car \_\_\_\_\_Church \_\_\_\_\_ Music \_\_\_\_\_ Work\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Select any that apply:

\_\_\_\_\_ I have been thinking that I might need hearing aids.

\_\_\_\_\_ I am ready to wear hearing aids if they are recommended.

\_\_\_\_\_ I need information about resources to help pay for hearing aids.

\_\_\_\_\_ I currently wear hearing aids.

Comments or questions for the audiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that the information presented above is true, according to my knowledge as of the date signed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Reviewed January 11, 2022

**Baylor University Speech-Language & Hearing Clinic**

**AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS**

I, ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ who resides at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the city of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the state of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize:

**Baylor University Speech-Language & Hearing Clinic**

**PO Box 97332**

**Waco, Texas 76798-7332**

to disclose the following specific health information by □ mail or □ fax or □ email to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, St., Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

from the Health Records of:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(NAME OF INDIVIDUAL WHOSE RECORD IS BEING DISCLOSED)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, St., Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My authorization extends only to those data elements/documents initialed below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnostic Reports

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing Reports

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Session Reports

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Results

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All of the above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (must be specific) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS**

**PAGE 2**

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, expect as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.
4. Baylor University, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S SIGNATURE (OR GUARDIAN, IF A MINOR)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT’S NAME PRINTED

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM ABOVE DATE)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WITNESS

**Baylor University Speech-Language & Hearing Clinic**

**P.O. Box 97332**

**Waco, TX 76798-7332**

**Release of Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RE: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom It May Concern:

I hereby grant permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose and deliver

(name of school/institution or above agencies)

any information requested by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ concerning my

(name of school/institution)

son/daughter \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This information may include case history, results of examination, impressions, and recommendations

that might benefit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in treating

(name of school/institution)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ speech and communication disorder.

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
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3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship

**Consent Agreement**

I understand that the Baylor University Speech and Hearing Clinic, hereafter referred to as the Clinic, is operated as a training center for speech-language pathologists and that all therapy conducted at the Clinic is supervised by a certified, licensed clinician and that all lessons may be observed by students in training or by students who may be interested in majoring in this field.

I further understand that many of the lessons are recorded by video and/or audio and that these lessons may be played in speech therapy classes as examples of speech, language, and hearing disorders or may be presented at professional meetings of doctors, dentists, psychologists, speech clinicians or other professional groups and that these recordings may be analyzed and the information used for research reports. I also understand that testing information and treatment progress as recorded in the client file may be used for research purposes. I further understand that when such usages are made of this information or recordings, that the names of the patients treated will be concealed.

I agree and understand that Baylor may freely use these recordings and files for purposes of education and research.

I further agree and understand that by signing this Consent Agreement, these recordings and files become the property of the Clinic and I hereby relinquish any and all claims to benefits, financial or otherwise which I had, now have, or may have in the future or which my heirs, executors, administrators, or assigns may have or claim to have from the use of these recordings.

BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date)