

**SPEECH AND HEARING CLINIC**  
CALIFORNIA STATE UNIVERESITY, LONG BEACH  
1250 BELLFLOWER BLVD.  
LONG BEACH, CA 90840  
(562) 985-4583

**ADULT**  
**INFORMATION QUESTIONNAIRE**

(All information given on this questionnaire will be considered confidential.)

Name of Applicant \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Relative \_\_\_\_\_ Phone \_\_\_\_\_

Name of person filling out questionnaire (if other than applicant) \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Person (or agency) referring you to this clinic \_\_\_\_\_ Official position \_\_\_\_\_

If you have been examined in this clinic before, give approximate date of last appointment \_\_\_\_\_

**SPEECH HISTORY**

Please describe the communication problem \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

How did it begin? (circle one)                      Gradually                      Suddenly

How was it called to your attention? \_\_\_\_\_

What languages do you speak? \_\_\_\_\_ When? \_\_\_\_\_

Name of examiner or clinic where you had your speech examined \_\_\_\_\_

Address \_\_\_\_\_

Name of Speech-Language Pathologist \_\_\_\_\_

Address \_\_\_\_\_

MEDICAL HISTORY

Doctor or Medical Group \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Are you taking any medication now? \_\_\_\_\_ For what? \_\_\_\_\_

Are you receiving any kind of treatment? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

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

Do you have any physical handicaps? \_\_\_\_\_ Describe \_\_\_\_\_

Have you had a hearing test? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Address \_\_\_\_\_

Provide the approximate ages at which you suffered the following illnesses and conditions:

Adenoidectomy _____	Allergies _____	Asthma _____
Chicken Pox _____	Colds _____	Convulsions _____
Croup _____	Dizziness _____	Draining Ear _____
Ear Infections _____	Encephalitis _____	German Measles _____
Headaches _____	Hearing loss _____	High Fever _____
Influenza _____	Mastoiditis _____	Measles _____
Meningitis _____	Mumps _____	Noise Exposure _____
Otosclerosis _____	Pneumonia _____	Seizures _____
Sinusitis _____	Tinnitus _____	Tonsillectomy _____
Tonsilitis _____	Other _____	

EDUCATIONAL HISTORY

Are you in school now? \_\_\_\_\_

If yes, name of school \_\_\_\_\_

Address of school \_\_\_\_\_

How far did you go in your education?

K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 \_\_\_\_\_

Bachelor's Degree \_\_\_\_\_ Master's Degree \_\_\_\_\_ Doctorate \_\_\_\_\_

