



## SPEECH, LANGUAGE, & HEARING CLINIC

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### ADULT INFORMATION QUESTIONNAIRE

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

Name of Applicant:

Birthday:

Gender:

Street Address:

City:

Zip:

Phone:

E-mail Address:

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

Relationship:

Primary Contact?

Yes

No

E-mail Address:

Phone:

Person (or agency) referring you to this clinic:

Official position:

SPEECH HISTORY (Please describe the communication problem)

How did the problem begin?

Gradually

Suddenly

Other

When did the problem begin?

What language(s) do you speak?

Name of facility where you have had your speech examined:

Address:

Name of Speech-Language Pathologist:

Contact Information

MEDICAL HISTORY

Doctor or Medical Group:

Phone:

Address:

Are you taking any medication now?

Yes

No

If yes, for what?

Are you receiving any kind of treatment?

Yes

No

If yes, please describe:

Do you have any physical handicaps?

Yes

No

Describe:

Have you had a hearing test?

When?

Where?

- Yes
- No

Address:

Please select whether you have suffered the following illnesses and conditions, and provide the approximate age(s) in which they occurred:

- |                                      |                                      |                                    |                                     |
|--------------------------------------|--------------------------------------|------------------------------------|-------------------------------------|
| <input type="radio"/> Adenoidectomy  | <input type="radio"/> Allergies      | <input type="radio"/> Convulsions  | <input type="radio"/> Chicken Pox   |
| <input type="radio"/> Colds          | <input type="radio"/> Draining Ear   | <input type="radio"/> Croup        | <input type="radio"/> Dizziness     |
| <input type="radio"/> German Measles | <input type="radio"/> Ear Infections | <input type="radio"/> Encephalitis | <input type="radio"/> High Fever    |
| <input type="radio"/> Headaches      | <input type="radio"/> Hearing Loss   | <input type="radio"/> Measles      | <input type="radio"/> Influenza     |
| <input type="radio"/> Mastoiditis    | <input type="radio"/> Noise Exposure | <input type="radio"/> Meningitis   | <input type="radio"/> Mumps         |
| <input type="radio"/> Seizures       | <input type="radio"/> Otosclerosis   | <input type="radio"/> Pneumonia    | <input type="radio"/> Tonsillectomy |
| <input type="radio"/> Sinusitis      | <input type="radio"/> Tinnitus       | <input type="radio"/> Tonsillitis  | <input type="radio"/> Asthma        |
| <input type="radio"/> Other          | <input type="text"/>                 |                                    |                                     |

Age(s) illness/condition occurred:

EDUCATIONAL HISTORY

Are you in school now?

If yes, what is the name of the school?

- Yes
- No

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
- Other

- Bachelor's Degree
- Master's Degree
- Doctorate