UNIVERSITY SPEECH, LANGUAGE AND HEARING CLINIC
A UNITED WAY FACILITY
100 CLINICAL RESEARCH CENTER
HOUSTON, TEXAS 77204-6018
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COGNITIVE CASE HISTORY QUESTIONNAIRE

I. Identifying Information

Client's Name _____ Date _____

Birthdate _____ Age _____ Sex _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Spouses work number (if applicable) _____

Client's present or former occupation _____

Client's hobbies _____

Spouse's name _____ Spouse's Age _____

Present Health of Spouse _____

Members of family _____

_____

Who lives with the client? _____

Client's education (last year completed) _____

Responsible Party _____ Relationship _____

Physician's name, address, zip code, and phone number: _____

_____

Relationship to client of person completing questionnaire _____

Have you been to this clinic before? If so, when? _____

Who referred you to this clinic? Name _____

Address _____ City _____ State _____ Zip _____

Are you a veteran of the US Armed Services? _____

Is patient Medicare-eligible? _____

Do you need an interpreter at the time of your appointment? If so, what kind? _____

_____

II. Information on the Client's Condition

1. What is caused the cognitive problem? Give medical diagnosis if known_____

_____

_____

_____

2. When did the problem (accident, operation, illness, etc.) occur?_____

_____

Was the client hospitalized?_____If so, how long and where?_____

_____

3. Does the client have any paralysis?_____Describe_____

_____

_____

4. How does the client get around? (Wheelchair, cane, walker, no assistive device needed)_____

_____

5. Is the client receiving therapy services at this time?_____If so, describe types of therapy (i.e.) physical; occupational)_____

_____

6. Does (s)he complain of headaches, faintness, or dizziness?_____

_____

_____

7. Is (s)he taking medication?_____If so, list each medicine and the dosage_____

_____

8. Has (s)he ever had convulsive seizures?_____If so, when did the last seizure occur?_____

_____

9. Is (s)he active?_____Describe_____

_____

10. Does (s)he tire easily?_____Describe_____

_____

11. Does (s)he complain that (s)he cannot see_____, hear_____, or feel_____things properly?

_____

12. Does the client wear glasses?_____Dentures?_____Hearing aids?_____

_____

13. Past significant medical problems? _____Describe_____

_____

_____

_____

III Information on Client's Cognitive and Communication Skills

1. Does the client have problems with memory? YES NO

If YES, is the problem with: Long-term memory, Short-term memory, Both

2. If the client has a problem with memory, please describe_____

_____

_____

_____

3. Describe any memory aides that the client uses_____

_____

_____

_____

4. Does the client have any of the following changes in behavior since the accident/illness?

Anger management	YES NO
Flat Affect	YES NO
Crying/Laughing not related to the situation	YES NO
Impulsive	YES NO
Unawareness/Unconcern of problem	YES NO
Changes in social skills/behavior	YES NO

5. Please describe any changes in behavior/personality:_____

_____

_____

_____

6. Does the client have a problem with communication YES NO If yes, please describe:_____

_____

_____

_____

7. How well does the family understand what the client is saying? Describe:_____

_____

8. Is English the dominant language of the client? _____Other languages spoken regularly by client or by family in the home:_____

9. Has the client had previous cognitive and/or communication therapy?_____

If so, when and where?_____

10. Is there anything else about this client and/or his speech problems that you think we should know?

11. How has the client reacted to his/her injury?_____