

UCA Speech-Language Hearing Center  
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APHASIA CASE HISTORY

General Information

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

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

Person filling out this form \_\_\_\_\_  
(name and relationship to client)

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

Person(s) or agency who referred you to the Clinic \_\_\_\_\_

Personal and Family History

Marital status: single \_\_ married \_\_ separated \_\_ divorced \_\_ widowed \_\_ remarried \_\_

Spouses address \_\_\_\_\_ Phone \_\_\_\_\_

| Children: | Names | Addresses | Ages  |
|-----------|-------|-----------|-------|
|           | _____ | _____     | _____ |
|           | _____ | _____     | _____ |
|           | _____ | _____     | _____ |
|           | _____ | _____     | _____ |
|           | _____ | _____     | _____ |

Grandchildren: Number \_\_\_\_\_ Ages \_\_\_\_\_

Medical Information

Date of injury (accident, illness, stroke) \_\_\_\_\_

What caused the injury \_\_\_\_\_

Was the client unconscious? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

Was the client paralyzed? \_\_\_\_\_ Describe \_\_\_\_\_

Did the client have convulsions? \_\_\_\_\_ Have they been controlled? \_\_\_\_\_

Does the client complain of dizziness, fainting spells, headaches? \_\_\_\_\_

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Does the client have any visual or hearing problems? \_\_\_\_\_

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Has the client been treated for other illnesses? \_\_\_\_\_ heart condition \_\_\_\_\_

Stroke \_\_\_\_\_ others \_\_\_\_\_

Name and address of physician \_\_\_\_\_

Has the patient been seen for any of the following services:

|   | <u>Date</u> | <u>Personal/Agency</u> | <u>Address</u> |
|---|-------------|------------------------|----------------|
| Speech Therapy                            | _____       | _____                  | _____          |
| Psychological<br>Counseling or<br>Testing | _____       | _____                  | _____          |
| Vocational Coun-<br>seling                | _____       | _____                  | _____          |
| Physical<br>Therapy                       | _____       | _____                  | _____          |
| Occupational<br>Therapy                   | _____       | _____                  | _____          |

Speech & Language Information

Describe what the client's speech was like at the onset of the problem \_\_\_\_\_

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How has it changed? \_\_\_\_\_

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Check the appropriate column as it applies to the client now. Add comments on the right side if needed to explain the answers.

Can      Cannot

- |     |     |  |
|-----|-----|--|
| ___ | ___ | Indicate meaning by gesture  |
| ___ | ___ | Repeat words spoken by others  |
| ___ | ___ | Uses none or a few words over and over   |
| ___ | ___ | Uses emotional speech (swear words); (counts or uses other words that occur in a series, days of week prayers) |
| ___ | ___ | Uses some words spontaneously  |
| ___ | ___ | Says short phrases   |
| ___ | ___ | Says short sentences   |
| ___ | ___ | Follows requests and understands directions  |
| ___ | ___ | Follows radio and television speech if short, simple   |
| ___ | ___ | Reads signs with understanding   |
| ___ | ___ | Reads numbers with understanding   |
| ___ | ___ | Reads single words   |
| ___ | ___ | Reads newspapers, magazines  |
| ___ | ___ | Tells time   |
| ___ | ___ | Copies numbers, letters  |
| ___ | ___ | Writes name without assistance   |

- \_\_\_    \_\_\_        Writes single words
- \_\_\_    \_\_\_        Writes sentences, letters
- \_\_\_    \_\_\_        Does simple arithmetic
- \_\_\_    \_\_\_        Personal care (dressing, shaving, etc.)
- \_\_\_    \_\_\_        Handles money

How did the client react when he discovered that speech was difficult? \_\_\_\_\_

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What was your reaction? \_\_\_\_\_

What do you do when the client cannot answer or when he/she tries to talk? \_\_\_\_\_

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How does the client react when he/she cannot say what he/she wants to? \_\_\_\_\_

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How does the client respond to personal contacts other than family members (friends, work associated)? \_\_\_\_\_

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Personal and Social Information

A. Before the injury:

Where did the client spend his/ her childhood? \_\_\_\_\_

Where did he/ she go to school? \_\_\_\_\_

How far did he/she go in school? \_\_\_\_\_

What is his/her occupation? \_\_\_\_\_ Did he/she like his/her work? \_\_\_\_\_

How long has he/she worked at this job? \_\_\_\_ What other work has he/she done? \_\_\_\_

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(give dates and length of time)

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What is the client's native language? \_\_\_\_\_ Does he/she speak any other? \_\_\_\_\_

What hobbies or special interests does he/she have? \_\_\_\_\_

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What did he/she like to read? \_\_\_\_\_

Which television programs did he/she enjoy? \_\_\_\_\_

Did he/she do much writing? (if so, what kind?) \_\_\_\_\_

Which hand did he/she prefer? \_\_\_\_\_

Describe the client's personality before the injury: \_\_\_\_\_

Nervousness \_\_\_\_\_

Shyness \_\_\_\_\_

Moods \_\_\_\_\_

Getting along with others \_\_\_\_\_

Meeting problems: gave up easily \_\_\_\_\_ kept on trying \_\_\_\_\_ other \_\_\_\_\_

**B. After the injury:**

How has the client reacted to the injury? \_\_\_\_\_

What seems to bother him/her the most? \_\_\_\_\_

What personality changes have you noted? \_\_\_\_\_

What is his/her attitude toward speech therapy? \_\_\_\_\_

Has the physician talked to you about the client's speech difficulty? \_\_\_\_\_

Any further information which may aid in the examination \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The UCA Speech Language Hearing Center shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.

