Communication Sciences and Disorders
Speech-Language and Hearing Clinics
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Audiology Clinic: Adult Client Intake Form

Client Information

Legal first name: Legal last name:

Preferred or lived name: Pronouns:

Date of Birth: Occupation:

Phone 1: Mobile Carrier:
Phone 2: Mobile Carrier:

Email address:

Mailing Address:
City: State: Zip:

Name of Primary Care Provider:

Emergency Contact Name:
Emergency Contact Relationship:
Emergency Contact Phone:
Emergency Contact Email:

If you are completing this form on someone's behalf:
Name of person completing form:
Relationship to client:
Phone: Email:

Contact person for scheduling or other questions:

Audiology Clinic: Adult Client Case History

1. Reasons for your visit (mark all that apply):

- ☐ I am concerned about my hearing
- ☐ Others have concerns
- ☐ Family history of hearing loss
- ☐ Other:
- ☐ Hearing aids
- ☐ Noise exposure
- ☐ Transferring Care

2. Have you ever had your hearing tested? ◯ yes ◯ no ◯ unsure

If so, when?

Were hearing devices recommended? ◯ yes ◯ no

3. Do you have hearing loss? ◯ yes ◯ no ◯ unknown

Which ears? ◯ right ◯ left ◯ both

Was it sudden or gradual?

Cause, if known:

4. Do you have difficulty listening in specific situations? (mark all that apply)

- ☐ Using the phone
- ☐ During quiet conversations
- ☐ In groups of people
- ☐ Women and children's voices
- ☐ Background noise
- ☐ Watching television
- ☐ Other:

5. Do you have family history of hearing loss before age 50? ◯ yes ◯ no ◯ unknown

If so, please list family members with hearing loss and their relationship to you:

6. Have you ever worn or tried hearing aids? ◯ yes ◯ no

If so, do you still wear them? ◯ yes ◯ no

Make and model, if known:

Please describe your experience:

7. Do you have a history of noise exposure? (mark all that apply) ◯ yes ◯ no ◯ unsure

This includes noise exposure for work, recreation, and hobbies.

- ☐ Military/law enforcement
- ☐ Firearms
- ☐ Industrial machinery
- ☐ Power tools
- ☐ Concerts
- ☐ Other:

Do/did you wear hearing protection? ◯ yes ◯ no

Case History – continued

8. Do you have a history of head trauma? ◯yes ◯no

(Examples: concussions, skull fractures, or other head injuries)

If so, please explain:

9. Have you had ear surgery? ◯yes ◯no

If so, which ears? ◯right ◯left ◯both

Dates and types of surgery:

10. Do you have a history of ear infections? ◯yes ◯no

If so, which ears? ◯right ◯left ◯both

When did they first occur? How often?

How were the infections treated?

11. Do you have any health problems, concerns, or conditions?

(Examples: asthma, diabetes, kidney disease, heart disease, lupus)

If so, please list:

12. Please list the name and dosage of any medications or supplements you take:

If you need more room, you may send your medication list as a separate page.

Case History - continued

13. Do you hear ringing, buzzing, or other noises (tinnitus) in your ears? ◯yes ◯no

If yes, please complete the Tinnitus Addendum.

14. Do you experience dizziness, imbalance, or vertigo? ◯yes ◯no

If yes, please complete the Dizziness Addendum.

15. Are you visiting our clinic for cochlear implant candidacy testing or for cochlear implant care? ◯yes ◯no

If yes, please complete the Cochlear Implant Addendum.

16. Are you interested in our hearing aid bank program which provides refurbished/donated hearing aids at no cost? ◯yes ◯no

If yes, please complete the Hearing Aid Bank Application Addendum.

17. What are your goals for hearing health?

18. Anything else we should know?

Please feel free to include any questions or concerns you may have.

Signature of Client or Representative: