KEY THERAPY
UNLOCK YOUR POTENTIAL

Adult History Form

As part of your evaluation, please complete the following form. Answer questions as completely as possible. This information is kept confidential and will be used to have a better understanding of your needs.

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Person Completing This Form: _____

Relationship to Client: _____

Who referred you for the evaluation? _____

Your medical concerns/diagnosis:

Reason for referral/appointment:

Primary doctor: _____

Address _____ Phone #: _____

HEARING HISTORY

When was your last hearing test? _____

Audiologist: _____ Phone: _____

When was your hearing loss diagnosed? _____

When did you start wearing hearing aids? _____

Cochlear implant surgery date: _____ Cochlear implant activation date: _____

Any other ear issues? _____
What are your concerns in regards to your listening skills?

_____

Speech skills? :_____

Have you had any previous testing or therapy for speech, language, or listening?
☐ Yes ☐ No

If yes, name of agency and date tested: _____

_____

Any other health issues that may be pertinent? _____

_____

Do you have any further questions?

_____

_____

_____

_____

Signature

_____

Relationship to Patient Date

_____