CALIFORNIA STATE UNIVERSITY, LOS ANGELES

Department of Communication Disorders
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Confidential

CALIFORNIA SPEAK OUT!® THERAPY & RESEARCH CENTER
IN COLLABORATION WITH PARKINSON VOICE PROJECT®

Date: _____

Robert L. Douglass Speech-Language Clinic
SPEAK OUT! Case History Form

Name: _____ **Pronouns:** _____

Address: _____
Number/Street City Zip

Cell Phone: ( ) **Work Phone:** ( )

Email: **May we contact you via email?** Yes ☐ No ☐

Date of Birth: **Age:**

Primary Language: **Secondary Language:**

Relationship Status: Married ☐ Single ☐ Partnership ☐ Widowed ☐

Name of person completing this form (if other than the client): _____

Relationship to Client: _____

Address: _____
Number/Street City Zip

Cell Phone: ( ) **Work Phone:** ( )

Email: **May we contact you via email?** Yes ☐ No ☐

Name of Person who referred to this clinic: _____

Professional Position: _____

Employer: _____

Education/Occupation

Highest level of education completed: Middle School ☐ High School ☐ Bachelors ☐ Masters ☐ PhD ☐ MD ☐

Degree Area: _____

Current occupation: _____

Name of Employer: _____

Medical History

When were you diagnosed with Parkinson's? _____

Age at time of diagnosis? _____

Name of Physician: _____

Address: _____
Number/Street City Zip

Phone: ( )

List any operations and serious illnesses and injuries

Illness, Injury, Operation	Date	Description

List any medications you are currently taking

Medication	Dosage	Reason

SPEAK OUT Information

When did you complete SPEAK OUT Therapy? _____

Who was your therapist? _____

Where? _____

How many sessions did you complete? _____

How often do you complete the SPEAK OUT! Exercises? _____

Do you participate in the on-line Speak OUT! Practice sessions? _____

What SPEAK OUT! Techniques are you **most** comfortable using? _____

What SPEAK OUT! Techniques are you **least** comfortable using? _____

What else should we know about your voice? _____