Calvert Health
Department of Speech Language Pathology
Aural Rehabilitation Case History Form

Patient Information:
Name:
DOB:
Preferred Mode of Communication:
Email Address:
Contact Phone Number:

Do you wish to have a licensed ASL interpreter available at your appointments? If 'yes', is there an interpreter you prefer?

Medical Team:
Audiologist:
PCP:
Surgeon:
Other Medical Provider(s):
*Please attach a copy of your current medications - dosage & times/day taken

Age of onset for hearing loss:
Known Medical Cause for Hearing Loss (eg:oto-toxic medication):
Did hearing acuity diminished over time?
Previous amplification prior to implant:

Please briefly describe speech therapy you previously participated in, and how long the service was provided.

Date of Cochlear Implant Surgery:
Date Cochlear Implant was Activated:

How has your ability to detect sound improved since the implant was activated?

Has your ability to discern speech sounds improved since the implant was activated?

Have you experienced any dizziness since the cochlear implant surgery? If ‘yes’, has it impacted your communication or ability to complete necessary tasks?

What is the primary mode of communication at school/work?

Who are your primary communication partners in your home environment?

Who are your primary communication partners in your school/work environment?

What are your current strategies for optimizing your listening environment in a group setting?

What are your current strategies for optimizing your listening environment during 1:1 communicative exchanges?

Have you used the phone for aural-oral communication?

What environments/situations are the most challenging to navigate using your implant & verbal communication?

Which environments/situations are the easiest for you to communicate?

Please provide areas of auditory comprehension, articulation, and/or voice you would like addressed. Do not hesitate to list any specific goals you wish to achieve.