



APHASIA RESEARCH CENTER
University of Maryland
0133, Lefrak Hall, College Park, MD – 20742
Tel: (301)405-2477
Fax: (301)314-2023

For Office Use Only
Confidential Code

PARTICIPANT HISTORY FORM

Personal and Family History

Name: _____

Sex: M F

Birthdate: _____

Age: _____

Address: _____

Phone: Home _____

Work: _____

Marital Status: _____

Handedness prior to injury:

Name of Spouse: _____

Right Left

Name of Legal Representative (if different from spouse): _____

Phone # of Legal Representative: _____

Address of Legal Representative: _____

Number of years of schooling: _____

Highest degree obtained: _____

Occupation before illness: _____

Are you presently employed: Y N Present occupation: _____

Native language: _____

Other languages: _____ Fluent Basic

Race (please circle one): American Indian/Alaska Native Asian Native

Hawaiian/Pacific Islander White Black/African American

Ethnic category (please circle one): Hispanic/Latino Not Hispanic/Latino

Name & relationship of the person filling out this form:

Medical History

Please circle appropriate responses:

Stroke	Y	N	Tremors	Y	N
# of strokes			Diabetes	Y	N
Head Injury	Y	N	Heart Disease	Y	N
Tumor	Y	N	High Blood Pressure	Y	N
Hemorrhage	Y	N	Allergies	Y	N
Coma	Y	N	Surgeries	Y	N
Progressive	Y	N	Describe		
Neurological Disease			Vision Deficit	Y	N
Brain/meningeal	Y	N	Glasses	Y	N
infection			Hearing Deficit	Y	N
Paralysis	Y	N	Hearing aid	Y	N
Arm	L	R	Drug use	Y	N
Legs	L	R	Alcohol use	Y	N
Face	L	R	Nicotine use	Y	N
Swallowing problem	Y	N	Present medication	Y	N
Memory Loss	Y	N	What?		
Depression	Y	N	Handedness	L	R
Confusion	Y	N			
Seizures	Y	N			

Please added any information on illness or problems circled Y above:

Hospitalization Y N

Duration of Hospitalization: _____

Name & address of the hospital: _____

Obtaining medical records

Name & address of the agency that has your most complete medical records:

May we obtain medical records pertinent to your current speech-language condition (e.g. neurologist's report regarding the stroke)? Y N

If yes, then please remember to sign the authorization at the end of this form.

Rehabilitation Y N

Duration of Rehabilitation: _____

Name & address of Rehabilitation Program:

Physical Therapy: Y N Duration:

Occupational Therapy: Y N Duration:

Speech Therapy: Y N Duration:

Any other therapy Y N Describe:

Speech-language history

Please describe the onset of your current speech-language condition:

Cause: _____

Date of onset: _____

How has your communication changed over time: _____

What is your primary mode of communication (circle below)?

Speech

Gesture

Writing

For each of the following areas, please describe your abilities & difficulties:

Speaking _____

Understanding speech _____

Reading _____

Writing _____

Using gestures _____

Understanding gestures _____

If you were bilingual, what languages can you currently:

Speak

Read

Write

Did you have any speech, language, or reading problems before the present illness?

Y N

If yes, describe: _____

Obtaining speech-language records

Name & address of the agency that has your most complete speech-language therapy records:

May we obtain your speech-language therapy records for the purpose of research only?

Y N

If yes, then please remember to sign the authorization at the end of this form.



APHASIA RESEARCH CENTER
University of Maryland
0133D, Lefrak Hall, College Park, MD – 20742
Tel: (301)405-2477
Fax: (301)314-2023

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

We are requesting authorization to access medical records pertaining to your head injury/stroke, including neurologist’s report, CT/MRI scans, medications administered, brain surgery, and any ongoing medical treatment for your neurological condition. This information is requested in order to document the neurological conditions that preceded your current language difficulties, and will be reported in published research papers as group data without any identifying information. For example, the information obtained from your medical reports may be reported as follows: *six out of ten participants in the study had a stroke involving the middle cerebral artery.*

Medical information from your neurologist, hospital(s) or clinic(s) will be obtained and viewed only by research personnel of the Aphasia Research Center of the University of Maryland, College Park. Medical records obtained in this manner will be used until the end of the research study.

You have the right to revoke this authorization for release of information by contacting the research personnel of the Aphasia Research Center at the above mentioned contact information, and signing the revocation clause at the end of this form. You may revoke the authorization with no penalty to you in terms of benefits for prior participation. However, your participation in future research projects will be limited. If you revoke the authorization, any information obtained before the revocation will be used to maintain the integrity of the research project.

Consent:

Permission is hereby given to the Aphasia Research Center of the University of Maryland, College Park, to secure medical reports for the purpose of research from the records of:

(Name of client)

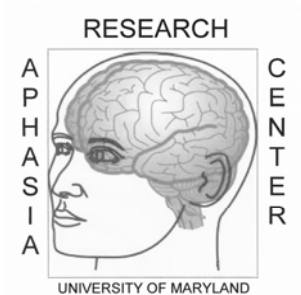
Signature Date

SS# _____

Relationship to client (if not signed by client): _____

Revocation:

I hereby revoke the permission to obtain medical reports _____



APHASIA RESEARCH CENTER
University of Maryland
0133, Lefrak Hall, College Park, MD – 20742
Tel: (301)405-2477
Fax: (301)314-2023

AUTHORIZATION FOR RELEASE OF SPEECH-LANGUAGE REPORTS

We are requesting authorization to access speech-language evaluation and treatment records pertaining to your present speech-language difficulties. This information is requested in order to document the onset and progress of your current speech-language difficulties, and will be reported in published research papers as group data without any identifying information. For example, the information obtained from your speech-language reports may be reported as follows: *six out of ten participants in the study received prior speech-language therapy, or all participants had difficulty naming verbs.*

Speech-language evaluation and treatment reports from you Speech-Language Pathologist(s) will be obtained and viewed only by research personnel of the Aphasia Research Center of the University of Maryland, College Park. Medical records obtained in this manner will be used until the end of the research study.

You have the right to revoke this authorization for release of information by contacting the research personnel of the Aphasia Research Center at the above mentioned contact information, and signing the revocation clause at the end of this form. You may revoke the authorization with no penalty to you in terms of benefits for prior participation. However, your participation in future research projects will be limited. If you revoke the authorization, any information obtained before the revocation will be used to maintain the integrity of the research project.

Consent:

Permission is hereby given to the Aphasia Research Center of the University of Maryland, College Park, to secure medical reports for the purpose of research from the records of:

(Name of client)

Signature

Date

SS# _____

Relationship to client (if not signed by client): _____