GW Speech, Language and Hearing Center
Foreign Accent Modification: Case History Form

Evaluator

Clinician's name: _____
Today's date: _____
Semester & year: _____

Pre-test or post-test? (circle one)

Client Contact Information

Client's full name: _____
Client's preferred name: _____
Address: _____
Email address: _____
Phone number: _____

Background Information

Date of birth: _____
Native country: _____
How long in US (years and months): _____
Native language/s: _____
Where and when did you learn English? _____
Were your instructors native English speakers (circle one)?
YES NO
Number of years spoken English: _____
Additional languages spoken: _____
Do you have a history of speech or language problems in your native language (circle one)?
YES NO

General

What % of time do you speak English on a typical weekday? _____
On a weekend? _____
Do people have difficulty understanding your spoken English (circle one)?
YES NO
If yes, describe: _____
Do you work (circle one)? YES NO
If yes, where and list responsibilities:
Are you in school (circle one)? YES NO
If yes, what year/program:
Are you a GA/TA (circle one)? YES NO
If yes, list responsibilities:

Has your accent impacted any of these factors (check all that are applicable)
☐Academic advancement
☐Professional interactions
☐Public speaking situations

☐Career advancement
☐Social interactions
☐Telephone conversations

What other areas do you have difficulty with (check all that are applicable)?
Pronouncing speech sounds such as
☐Grammar
☐Understanding lectures or presentations
☐Understanding social conversations
☐Being understood in academic situations
☐Being understood in social situations
☐Using and understanding idioms/slang
☐Other: _____

Do you have concerns about your hearing (circle one)? YES NO
Do you have concerns about your vision (circle one)? YES NO