



NEURO

Adult Case History Form

Name: _____ Date: _____

Date-of-birth: _____ Age: _____

Address: _____

Phone: _____ Alternate Phone: _____
Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address: _____

Occupation/former occupation: _____ Employer: _____

Highest Level of Education Completed: _____

Name of Spouse or Nearest Relative: _____

Native Language: _____ Primary Language: _____

Physician's name: _____ Phone: _____

Referred by: _____

Person completing this form: _____ Relationship: _____

CONCERN

1. What happened to cause the difficulties that you are experiencing now? When did this event happen?

2. List all previous communication therapy.

3. Why do you wish to be evaluated at our clinic? Please describe your communication problem.



4. What would you hope to gain through the use of our services?

5. Are there any particular times of the day when your situation is better or worse? If so, please explain.

6. Please indicate if you are currently experiencing any of the following:

- Oral weakness (in the mouth or lips)
- Difficulty producing the sounds in words
- Difficulty recalling the words that you want to say
- Difficulty understanding others when they speak
- Difficulty reading or writing
- Difficulty remembering
- Difficulty paying attention
- Difficulty solving problems/overall changes in my thinking ability
- Difficulty eating or swallowing
- Difficulty hearing
- Changes in your vision
- Changes in your voice
- Any other changes or difficulties that we should be aware of?

Explain: _____

MEDICAL

1. Have you had a recent or prolonged illness? If so, please describe.

2. Are you presently taking any medication? If so, please list and indicate reason for taking them.

3. Describe any surgery you have had. Indicate the year.

4. Describe any significant accidents you have had and indicate dates.

5. Have you had any other medical conditions that we should be aware of?
