



Speech/Language - 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 _____

COMPLAINT

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

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

3. When and where did you have previous communication therapy? Please describe:

4. Are there any particular times of the day or situations in which your problem is worse? If so, please describe:

5. Are there any particular times of the day or situations in which your problem is better? If so, please describe:

6. Have any other members of your family had a communication problem? If yes, please describe:

7. Have you ever experienced any of the following? Please check.

Approximate Date(s) Year

- _____ _____ Difficulty saying the sounds of English
- _____ _____ Difficulty recalling the words you wish to say
- _____ _____ Voice problems
- _____ _____ Hearing problems

MEDICAL

1. Have you had any 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 year of surgery.

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

5. Have you ever had any of the following? Please check.

Approximate Date(s) Year

- | | | | |
|-------------|--------------------------|-------------|-------------------------|
| _____ _____ | Influenza | _____ _____ | Scarlet fever |
| _____ _____ | Heart disease | _____ _____ | Meningitis |
| _____ _____ | Weakness of arms or legs | _____ _____ | Allergies |
| _____ _____ | Uncontrolled trembling | _____ _____ | Sinus problems |
| _____ _____ | Difficulty in swallowing | _____ _____ | Frequent colds |
| _____ _____ | Shortness of breath | _____ _____ | Thyroid problems |
| _____ _____ | Measles | _____ _____ | Other (please describe) |