Adult Case History Form

Name of Person Completing this Form: ______________________________

Relationship to Client: ______________________________

Client's Name: ____________________ Birth Date: __________ Age: _____

Address: ____________________

____

Home Phone: ____________________ Alternate Phone: ______________

Referring Physician: ________________ Family Physician: ______________

Primary Language: ________________

Reason for referral: ______________________________

What information do you hope to obtain from this evaluation? ________________

____

Medical History

Date of onset or diagnosis: ______________________________

Please describe the speech/language/swallowing difficulties:

____

____

____

____

If known, what is the cause of the speech/language/swallowing difficulty?

____

Has the speech/language/swallowing problem changed since first diagnosed? Please describe.

____

____

Hospitalization:

Dates:	Hospital (s):	Reason(s):
____________	______________	______________
____________	______________	______________
____________	______________	______________

Test(s) completed: (Please circle those that apply.)

MRI CT Scan Chest X-Ray Other:

Do you have any difficulty eating or drinking? ______________________________

Previous Medical History: (Circle all that apply)
Headaches Dizziness Encephalitis Hearing Loss Pneumonia
Seizures PEG Tube Diabetes Hypertension Respiratory Issues
Cardiac Issues CVA (Stroke) (Date: _______) Head Injury (Date: _______)
Other: ____

Do you use any of the following assistance devices?
_____ Wheelchair
_____ Walker
_____ Cane
_____ Other ______________________________

Do you have problems with hearing or vision? Please explain:
____

Do you wear glasses? Yes No Hearing Aid(s)? Yes No

Have you ever been referred to any of the following specialists? (circle those that apply)
Audiologist Otolaryngologist (ENT) Gastroenterologist Neurologist
Psychologist Psychiatrist Occupational Therapist Physical Therapist

If yes, please state the reason and results:
____
____
____

List all current medications and what they are prescribed for:
____
____
____

Have you ever been evaluated by or had treatment with a Speech Language Pathologist?
Yes No When? _____________ Reason/Results? ________________
____

Educational History

Highest grade completed: ____
Degree(s): ____
Name of Institution: __________________________________
Have you ever had difficulty with the following areas prior to your illness or accident?
(circle all that apply)
Understanding Reading Speaking Writing Math
Attention Memory Problem Solving

Work History

Currently Employed? Yes No Date of Retirement: ____________________
Occupation: ____________________
Place of Employment: ____________________
Job Duties:

____

____

Are you currently driving? Yes No

What are your household responsibilities? (circle all that apply)

Computer tasks	Balancing checkbook	Grocery shopping	Cooking
Cleaning	Child Care	Yard Work	Household Repairs
Laundry	Driving	Other: ____________________	

Have you had to stop doing any of your previous activities? If yes, what and why?

____

____

____

Please list any specific hobbies, interests, or social activities: ____________________

____

Family History

Spouse's Name: ____________________
Child(ren)'s Name(s): ____________________ Age: _______
____________________ Age: _______
____________________ Age: _______
____________________ Age: _______
Do you have any family history of speech/hearing problems? Yes No
Please explain:

____

____

Do you have any family/friends who can (or do) assist you throughout the day?

____

List any other information you would like us to know about related to your speech, language or swallowing difficulties:

____

____

____

Thank you for completing this form. The information you have provided will assist us in preparing for your evaluation.