Speech Therapy Case History Form- Adult

General Information

Name:_____ Date of Birth: _____

Referred to this clinic by: _____ Primary Care Physician:_____

Spouse/partner's name: _____

Occupation: _____ Business Phone: _____

If retired, from what: _____ Home phone: _____

Daytime phone: _____ Cell Phone:_____

Are you: ___single; ___married; ___divorced; ___widowed

Children (names, gender, ages):_____
_____
_____

Who lives in your home?
_____
_____

Communication History

Describe your current speech, language, cognition (memory, thinking, reasoning), respiratory or swallowing difficulties.
_____
_____
_____
_____

When was the problem first noticed? By whom?
_____
_____

What do you think may have caused the problem?

Are there situations where the problem is better/worse?

Have you seen any other speech-language specialist(s)? Who and when? What were their conclusions or suggestions?

What have you done to try to improve your communication or current difficulty? What were the results?

How do you feel your communication problem has affected your social life, career, education, etc.?

Have you seen any other specialist (physical/occupational therapists, surgeons, physicians, psychologists, neurologists, etc.) concerning your problem? If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

Are there any speech, language, voice, hearing, or respiratory problems in your family? If yes, please describe.

What are your goals for coming to the clinic at this time?

Medical History

Please check the following if they apply:

Hearing Loss _____	Allergies _____	GERD/Reflux _____
Noise Exposure _____	Dizziness _____	LPR _____
Ear Infections _____	Encephalitis _____	Depression _____

Seizures	_____	High Fever	_____	Head Injury	_____
Otosclerosis	_____	Meningitis	_____	Stroke	_____
Sinusitis	_____	Measles/Mumps	_____	Concussion	_____
Tinnitus	_____	Mastoiditis	_____	Headaches	_____
Pneumonia	_____	Chronic Cough	_____	Anxiety	_____
Asthma	_____	Difficulty Breathing	____	Voice Problems	_____

Other_____

Is there a history of:

	Yes	No	
Smoking	___	___	How much per day? _____
Drinking	___	___	How much per day? _____

Describe your present health.

_____
_____
_____
_____

Please describe any medical problems you are currently experiencing.

_____
_____
_____
_____

Do you have any eating or swallowing difficulties? If yes, please describe.

_____
_____
_____
_____
_____
_____

List all medications and the purpose for each. Please use the back if you need more room.

_____
_____
_____
_____

Are you having any negative reactions to these medications? If yes, please describe.

_____
_____

Describe any major surgeries or hospitalizations (including dates).

Describe any major accidents.

In the space below, please provide any additional information that might be helpful in the evaluation or treatment process.

Person Completing Form: _____
Relationship to Client: _____
Signature: _____Date: _____