LAKESHORE
SPEECH THERAPY, LLC

Adult Case History Form

Please complete the following form and bring it to your scheduled evaluation.

Name: _____ **Today's Date:** _____
Physician: _____ **Date of Birth:** _____
Address: _____ **Age:** _____
City/State/Zip: _____ **Phone Number:** _____
Email: _____ **Cell/Work Number:** _____

Reason/Person for Referral:

_____

_____

A. Background Information:

1. What are your current concerns regarding your speech, language, swallowing, or motor skills?

_____

_____

_____

2. What do you think caused the above difficulties?

_____

_____

_____

3. When was the problem first noticed?

_____

_____