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?
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____
____

2. What do you think caused the above difficulties?

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____
____

3. When was the problem first noticed?

____
____

4. Has the problem changed (worsened/ resolved) since it was first noticed? Describe.

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____
____
____
____

5. Have you ever seen a specialist/therapist regarding these difficulties? Who and when? What were their conclusions/recommendations? If so, do you have copies or may we obtain copies of progress and/or discharge reports?

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____
____
____

B. **Medical History:**

1. Do you currently have any medical diagnoses? If so, what are they?

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____

2. Have you ever had surgery or been hospitalized for any reason in the last 1-2 years? If yes, please list and indicate approximate dates.

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____

3. Do you/ have you suffered from any illnesses or medical conditions? If yes, please list:

____
____
____

4. Are you currently taking any medications? Please list.

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____

5. Do you have any known allergies? (medications, foods, latex, seasonal, etc.) Please list.

____

6. Has your hearing been evaluated? If so, indicate where, when, and the status of that evaluation.

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7. Do you use English as a second language? If so, what is your native language?

____

9. Although an accent is not a disorder, do you find an accent is affecting your ability to communicate?

____

C. Family/ Social History:

1. Indicate current marital status: Single ___ Widowed ___ Divorced ___ Married ___

Spouse's Name if applicable:

____

2. Describe current or past occupation/employer:

____ ________________________________
____

3. Highest grade, diploma, or degree earned.

____
____

4. List any children (names, gender, and ages):

____
____

5. List who is currently living in your home and in what setting (i.e. 2-story house, 2nd floor apt, etc.).

____

6. Is there any family history of speech, language, learning, hearing, medical or mental health issues?
Describe.____
____
____

7. List hobbies/interests:

____

8. What is the best way you learn new things?

___Written instruction ___Demonstration
___Verbal instruction ___Hands-on learning
___Other:____

D. Therapy History:

1. Have you ever received any type of therapy (speech/language, occupational, physical)? If, so indicate which type(s) and durations.

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2. If applicable, please list conditions treated in therapy.

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____

E. Speech and Language Skills:

1. Do you have difficulty expressing your wants and needs? If yes, please explain.

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____

2. Do others find you difficult to understand? If yes, please explain.

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____

3. Do you find it hard to understand others? If yes, please explain.

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4. Do you have short-term and/or long term memory difficulties? If yes, please explain.

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____
____

5. Do you have difficulty with word-finding (i.e. remembering the names of objects and/or people)? If yes, explain.

____

6. Do you have difficulty with reading or writing? If yes, please explain.

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________ ____

7. Has there been any changes to your voice (i.e. hoarse, breathy, loss of volume)? If yes, please explain.

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____
____

G. Swallowing Skills:

1. Please indicate (check mark) if you have difficulty with any of the following:

___ Chewing Food ___ Drooling ___ Moving food to the back of the mouth
___ Managing Liquids ___ Increased meal times ___ Watery eyes when eating/drinking
___ Coughing ___ Holding cup/utensils ___ Clearing food/ liquid from the mouth
___ Choking ___ Other ____

2. Are you currently on a modified food and/or liquid diet? If yes, please explain.
____
____

3. Are their food/liquid textures that you avoid?
____
____

4. Do you currently wear dentures? Indicate full or partial.
____

H. Activities of Daily Living:

1. Do you require assistance with any of the following?:

___ Dressing ___ Toileting ___ Money Management/ Bill Payments
___ Cooking ___ Transportation/ Driving ___ Keeping track of appointments
___ Eating ___ Showering/ Personal Hygiene ___ Moving/ walking from place to place
___ Telling Time ___ Making phone calls ___ Grocery Shopping
___ Housekeeping ____ Other
____

2. Do you have any difficulties with fine motor skills to be able to manipulate clothing fasteners, utensils, opening jars, keyboarding, etc.? If yes, please explain.

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I. Therapy Goals:

1. What are your current speech/language related goals/expectations?
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2. Are there any issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy?
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****Please provide any additional information that may be helpful to the evaluation/treatment process:**
____
____
____

Completed by ___________________________ on ________________ (date).

THANK YOU!

PLEASE BRING TO INITIAL THERAPY APPOINTMENT OR FAX TO 480-287-8108.