13611 Skinner Road, Suite 250
Cypress, Texas 77429
1110 Enclave Parkway
Houston, TX 77077
(832) 593-6767
(832) 593-6868 Fax

ADOLESCENT AND ADULT CASE HISTORY

PATIENT'S NAME:		PHYSICIAN'S NAME:	
DATE OF BIRTH:		PHYSICIAN PHONE NUMBER:	
AGE:		PHYSICIAN FAX NUMBER:	
OCCUPATION/SCHOOL:		INSURANCE NAME, ADDRESS, AND PHONE NUMBER*:	
ADDRESS:		MEMBER ID:	
HOME PHONE NUMBER:		GROUP #:	
CELL PHONE NUMBER:		HOW DID YOU HEAR ABOUT US?:	
SPOUSE/PARENT'S NAME AND PHONE NUMBER:			

*** Please include a front and back copy of your insurance and driver's license with this form.**

REASON FOR EVALUATION:

_____

_____

_____

_____

_____

MEDICAL HISTORY:

PRIMARY CARE PHYSICIAN		
OTHER SPECIALISTS/ PHYSICIANS THAT SEE THE CLIENT	Name: Name: Name:	Phone number: Phone number: Phone number:

ILLNESSES, INJURIES, OPERATIONS	Date	Severity		Complications
HEARING:	Date Tested:		Results:	
VISION:	Date Tested:		Results:	
If applicable- Please provide caregiver's name and phone number:				
ALLERGIES:				
MEDICATIONS: (Please include vitamins, herbal supplements, and/or natural remedies)	Name: Name: Name: Name: Name:	Dosage: Dosage: Dosage: Dosage: Dosage:		Route: Route: Route: Route: Route:
Do you have any physical difficulties? If so, please describe.				
Have you had any therapies besides speech? (i.e., occupational therapy, physical therapy)				
Do you have any swallowing difficulties? If so, please describe.				

OTHER INFORMATION:

_____

_____

_____

SPEECH AND LANGUAGE INFORMATION

HOW MUCH OF THE CLIENT'S SPEECH IS UNDERSTOOD BY:	FAMILIAR PEOPLE?	%	UNFAMILIAR PEOPLE?	%
ONSET OF PROBLEM:				
SEVERITY OF PROBLEM:	SEVERE	MODERATE	MILD	
DESCRIPTION OF THE PROBLEM:				
LANGUAGE(S) IN THE HOME:				

HAS THE CLIENT EVER BEEN EVALUATED FOR SPEECH THERAPY?	Date:	Provider Information:
	Date:	Provider Information:
ADDITIONAL STUDIES PERFORMED?		

OTHER INFORMATION:

_____

_____

_____

OTHER INFORMATION:

_____

_____

_____

FAMILY:

LIVING SITUATION (With whom do you live?)	
OCCUPATION/SCHOOL:	
NAME of WORK/SCHOOL:	

OTHER INFORMATION:

_____

_____

_____

_____

_____

SIGNATURE: _____ DATE: _____