Speech Language & More, Inc.

Rehabilitation Services for Children and Adults

ADULT CASE HISTORY FORM

Identifying Information

Name:_____ D.O.B._____ Sex: ❑ M ❑ F

Daytime Phone: _____ Cell Phone: _____

Address: _____ E-mail: _____

_____

Contact Name: _____ Relationship to Patient: _____

Address: _____ E-Mail: _____

_____

Daytime Phone: _____ Cell Phone: _____

Dr.'s Name:_____ Dr.'s Phone:_____ Fax:_____

Reason for Referral: _____

Family/Social Information

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Name of Spouse _____

Children's name and ages:

_____ _____

_____ _____

Who do you live with? _____

Occupation _____

Interests and hobbies _____

Highest level of education completed:

❑ High School ❑ Associate's ❑ Bachelor's ❑ Master's ❑ Ph.D. ❑ Other

Are languages other than English spoken at home? ❑ Yes ❑ No
If yes, which one?_____

Please describe how you communicate (e.g. words, gestures, writing): _____

_____

Medical History

Please indicate whether or not you have had any of the following illnesses or conditions:

(For any "yes" responses, please explain below)

Accidents	❑Yes	❑No	Neurological	❑Yes	❑No
Adenoidectomy	❑Yes	❑No	Noise Exposure	❑Yes	❑No
Allergies	❑Yes	❑No	High Fever	❑Yes	❑No
Asthma	❑Yes	❑No	Meningitis	❑Yes	❑No
Cancer/Tumor	❑Yes	❑No	Multiple Sclerosis	❑Yes	❑No
Concussion	❑Yes	❑No	Otosclerosis	❑Yes	❑No
Dementia	❑Yes	❑No	Paralysis	❑Yes	❑No
Diabetes	❑Yes	❑No	Pneumonia	❑Yes	❑No
Dizziness	❑Yes	❑No	Sinusitis	❑Yes	❑No
Ear Infections	❑Yes	❑No	Stroke	❑Yes	❑No
Encephalitis	❑Yes	❑No	Surgery	❑Yes	❑No
Epilepsy	❑Yes	❑No	Thyroid Problem	❑Yes	❑No
Headaches	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Head Injury	❑Yes	❑No	Voice Problems	❑Yes	❑No
Heart Problem	❑Yes	❑No	Cleft Lip/Palate	❑Yes	❑No

If you answered yes to any of the above items, please explain in detail: _____

_____

_____

Please describe any other medical conditions you may have that are not listed above: _____

_____

_____

Are you currently (or recently) under a physician's care? ❑Yes ❑No

If yes, why? _____

_____

Have you ever been hospitalized? ❑Yes ❑No

If yes, please describe and provide dates: _____

_____

Current Medications (prescription/non-prescription): _____

_____

Speech-Language-Hearing

Describe your speech/language concern(s): _____

_____

_____

Have you ever attended speech-language-hearing therapy? ❑Yes ❑No

Where and when? _____

How often were you seen for therapy? _____

How long were you in therapy? _____

What were you working on? _____

_____

Have you ever received any other evaluation or therapy (e.g. physical therapy, counseling, occupational therapy, vision)? ❑Yes ❑No

If yes, please describe: _____

Do you have a hearing problem? ❑Yes ❑No

In which ear? ❑Right ❑Left ❑Both

When was the onset of your hearing loss? _____

Was the onset: ❑Sudden ❑Gradual

Has your hearing loss been gradually progressive in nature? ❑Yes ❑No

Does your hearing fluctuate from day to day? ❑Yes ❑No

What was the cause of your hearing loss? _____

Do you experience any sounds ("tinnitus") in your ears or your head? ❑Yes ❑No

Do you ever experience dizziness, balance problems or spinning sensations? ❑Yes ❑No

If yes, please describe: _____

Do you wear a hearing aid? ❑Yes ❑No

Swallowing Information

Do you have trouble swallowing? (If yes, please answer the following questions) ❑Yes ❑No

When did the swallowing problem start? _____

Please describe in detail the nature of the swallowing problem: _____

_____

Has the swallowing problem gotten better or worse? ❑Yes ❑ No

If yes, please describe: _____

_____

Does the swallowing problem happen with certain foods or liquids? (Please describe.) _____

_____

Are you on a special or modified diet? ❑Yes ❑No

Does the swallowing problem happen at different times of the day? (Please describe.) _____

_____

Have you had a swallowing study in the past? ❑Yes ❑No

If so, when? _____

What were the results? _____

Cognitive Information

Do you have difficulty with your memory? ❑Yes ❑No

Do you have difficulty paying attention? ❑Yes ❑No

Do you have difficulty with problem solving and reasoning? ❑Yes ❑No

Please describe your cognitive difficulties: _____

_____

Additional Comments

_____

_____

_____

_____