



## ADULT CASE HISTORY FORM: SPEECH-LANGUAGE PATHOLOGY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email (optional): \_\_\_\_\_

Occupation \_\_\_\_\_

Family physician: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Person filling out this form (circle one): self other: \_\_\_\_\_

What do you hope to get out of speech therapy?

What is your primary language? What other language do you speak?

**MEDICAL HISTORY:** Please check all that apply. Please provide the dates where applicable

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Hearing loss                        |
| <input type="checkbox"/> Heart troubles          | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Cerebral palsy                      |
| <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Head/neck cancer | <input type="checkbox"/> Intellectual deficits, MR           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Shingles         | <input type="checkbox"/> Cleft palate                        |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Bronchitis       | <input type="checkbox"/> Chronic colds                       |
| <input type="checkbox"/> Chronic laryngitis      | <input type="checkbox"/> COPD             | <input type="checkbox"/> Facial nerve palsy                  |
| <input type="checkbox"/> Acid reflux             | <input type="checkbox"/> Sinusitis        | <input type="checkbox"/> Emotional or psychological issues   |
| <input type="checkbox"/> Ear infections          | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Multiple sclerosis                  |
| <input type="checkbox"/> Meningitis              | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Huntington's or Parkinson's Disease |
| <input type="checkbox"/> Seizures                | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Voice issues or changes             |
| <input type="checkbox"/> Head injury             | <input type="checkbox"/> Thyroid issues   | <input type="checkbox"/> Vocal polyps or nodules             |
| <input type="checkbox"/> Neurological conditions | <input type="checkbox"/> Arthritis        |  |



What is your current state of health?

- Excellent
- Average-fair
- Poor

Have you been hospitalized within the last 5 years? If so, why? Where?

Please list any medications you are taking at this time:

Do you use any of the following assistance devices?

- Wheelchair
- Walker
- Cane
- Other
- None

Are you able to climb stairs: \_\_\_\_\_ Yes \_\_\_\_\_ No

**SPEECH-LANGUAGE HISTORY (Check column):**

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			



Are there any other difficulties besides what is listed above?

When was this problem first noticed?

Did the problem begin suddenly or develop over time?

Have you been seen by any other rehabilitation professionals?

- Speech therapy: where: \_\_\_\_\_ when: \_\_\_\_\_
- Physical Therapy: where: \_\_\_\_\_ when: \_\_\_\_\_
- Occupational Therapy: where: \_\_\_\_\_ when: \_\_\_\_\_
- Other:

Does this speech-language difficulty impact your ability to function in daily life?

How or where does the speech-language difficulty impact you the most?

Describe your daily communication needs:

What do you hope to get out of speech-language therapy?

**SOCIAL AND EDUCATIONAL HISTORY:**

1. Marital Status:

- Single
- Married
- Divorced
- Widowed

2. Spouse or partner's name: \_\_\_\_\_

3. Children:

Names	Ages



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4. Occupation: \_\_\_\_\_

Do you currently work? \_\_\_\_\_ YES \_\_\_\_\_ NO

5. Employer: \_\_\_\_\_

6. Highest level of education (grade or degree) completed.

\_\_\_\_\_

Please provide other information you believe to be helpful in the development of your care. Thank you.

\_\_\_\_\_  
Patient or Caregiver

\_\_\_\_\_  
Date