Adult Case History Form

Name of Person Completing this Form: ____

Relationship to Client: ____

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Client's Name: ______________________________ Birth Date: __________________ Age: ___________

Address: ____

Home Phone: _____________________________ Alternate Phone: ______________________________

Referring Physician: ________________________ Family Physician: ______________________________

Primary Language: _________________________

Reason for referral: ____

Medical History

Date of onset or diagnosis: ___________________________________

Please describe the speech/language/voice/swallowing difficulties:

____

____

____

If known, what is the cause of the speech/language/voice/swallowing difficulty?

____

____

Has the problem changed since it was first noticed? Please describe.

____

____

Have you seen any other speech-language specialists? Who and when? What were their conclusions or suggestions?

____

____

Have you seen any other specialists (neurologist, audiologist, otolaryngologist (ENT), gastroenterologist (GI), psychologist, psychiatrist, occupational therapist, physical therapist, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions.

____

____

Hospitalization:

Dates:	Hospital(s):	Reason(s):
________________	______________________________	______________________________
________________	______________________________	______________________________
________________	______________________________	______________________________
________________	______________________________	______________________________

Do you have any eating or swallowing difficulties? If yes, describe.

____

____

Previous Medical History: (Circle all that apply)

Headaches Dizziness Encephalitis Hearing Loss Pneumonia Seizures

PEG Tube Diabetes Hypertension Respiratory Issues Cardiac Issues

CVA (Stroke) (Date: ___________) Head Injury (Date:____________)

Other: ____

What information do you hope to obtain from this evaluation?

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