ADULT CASE HISTORY

SPEECH THERAPY CENTER OF EXCELLENCE

Name of Person Completing this Form_____

Relationship to Client _____

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 difficultiesz_____

_____

_____

_____

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

Date	Hospital(s	Reason(s)

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

_____

_____

_____

Previous Medical History: (Circle all that apply)

Headaches	Pneumonia	Hypertension
Dizziness	Seizures	Respiratory Issues
Encephalitis	PEG Tube	Cardiac Issues
Hearing Loss	Diabetes	

CVA (Stroke) (Date_____) Head Injury (Date_____)

Other_____

What information do you hope to obtain from this evaluation?_____

_____

_____

_____

_____