

ADULT CASE HISTORY FORM: SPEECH-LANGUAGE PATHOLOGY

Name: _____ **Age** _____ **Male** ___/ **Female** ___ **Date of birth:** _____

Address: _____

Phone: (Home) _____ **(Mobile)** _____ **(Work)** _____

Email: _____

Family physician: _____ **Referring physician:** _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

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

What do you hope achieve through speech evaluation and therapy?

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

Medical history: please check all that apply. Please provide the dates and additional information where applicable:

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Head/Neck Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emotional or Psychological Issues
<input type="checkbox"/> Heart Troubles	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Shingles	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizures	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Huntington's or Parkinson's Disease

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Head Injury	<input type="checkbox"/> COPD	<input type="checkbox"/> Intellectual Deficits, MR	<input type="checkbox"/> Voice Issues or Changes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neurological Conditions	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Cleft Palate	<input type="checkbox"/> Vocal Polyps or Nodules
<input type="checkbox"/> Chronic Laryngitis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Other:
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Cancer	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Facial Nerve Palsy	

What is your current state of health? Excellent _____ Average-Fair _____ Poor _____

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

What medical procedures or surgeries have you had? Please include dates.

Please list any medications you are taking at this time:

SPEECH-LANGUAGE HISTORY

Symptom (Difficulty with any of the following)	Never	Sometimes	Frequently
Swallowing			
Expressing thoughts			
Difficulty being understood by others			
Understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Symptom (Difficulty with any of the following)	Never	Sometimes	Frequently

Maintaining topic of conversation			
Dysfluent 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 this problem was first noticed?

Did the problem begin suddenly or develop over time?

Have you been seen by any other rehabilitation or medical professionals for evaluation or treatment?

Speech therapy: where: _____ when: _____

Physical Therapy: where: _____ when: _____

Occupational Therapy: where: _____ when: _____

Other:

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

In which circumstances does the speech-language difficulty impact you the most?

Describe your daily communication needs:

SOCIAL AND EDUCATIONAL HISTORY

1. Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

2. Spouse or partner's name: _____

3. Children:

Names	Ages

4. Occupation: _____

Do you currently work? _____ YES _____ NO _____ RETIRED

5. Employer or Previous Employer:

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

Please provide any other information you believe to be helpful so we at Goepfert Speech Associates, LLC can provide you with the best care to meet your needs.

Patient/Caregiver Signature

Date