GOEPFERT SPEECH ASSOCIATES
Gayle Z. Goepfert, M.S., CCC/SLP
Speech and Language Pathologist

431 East Chocolate Avenue
Hershey, PA 17033
Phone/Fax: (717)-533-1916
GoepfertSpeechAssociates@gmail.com

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 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:

☐ Heart Attack	☐ Ear Infections	☐ Head/Neck Cancer	☐ Asthma	☐ Emotional or Psychological Issues
☐ Heart Troubles	☐ Meningitis	☐ Shingles	☐ Hearing Loss	☐ Multiple Sclerosis
☐ Hypertension	☐ Seizures	☐ Bronchitis	☐ Cerebral Palsy	☐ Huntington's or Parkinson's Disease

☐ Diabetes	☐ Head Injury	☐ COPD	☐ Intellectual Deficits, MR	☐ Voice Issues or Changes
☐ Stroke	☐ Neurological Conditions	☐ Sinusitis	☐ Cleft Palate	☐ Vocal Polyps or Nodules
☐ Chronic Laryngitis	☐ Allergies	☐ Tuberculosis	☐ Chronic Colds	☐ Other:
☐ Acid Reflux	☐ Cancer	☐ Pneumonia	☐ 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	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			

Symptom	Never	Sometimes	Frequently
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 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

5. 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 can provide you with the best care to meet your needs.

_____

Patient/Caregiver Signature Date