ADULT CASE HISTORY FORM

Name of Person Completing this Form: _____

Relationship to Client: _____

Client's Name	
Date of Birth	
Age	
Address	
Home Phone Number	
Cell Phone Number	
Email	
Primary Physician	
Primary Physician Address	
Reason for Referral	
What information do you hope to obtain from this evaluation?	

MEDICAL HISTORY

Date of onset of diagnosis	
Description of the speech and language difficulties	
If known, what is the cause of the speech/ language problem?	
Has the speech/language problem changed since first diagnosed? If yes, please explain.	
Hospitalizations	
Tests: (circle all that apply)	MRI CT Scan Chest X-ray Other _____
Do you have difficulty eating or drinking? If yes, explain in what situations.	

Previous Medical History: (circle all that apply)	Headache Dizziness Hearing Loss Pneumonia Cardiac Issues Stroke (CVA) • Date Other: _____	Seizures PEG Tube Diabetes Hypertension Respiratory Issues Head Injury • Date Other: _____
Vision or Hearing Problems		
Hearing Aid(s)		
Referred to any specialists? (circle those that apply and explain the reason and results)	Audiologist ENT Gastroenterologist Neurologist Psychologist Psychiatrist PT/OT	
Current Medications		

Ever seen a speech language pathologist before? If yes, explain when and for what reason.	

Educational History

Highest grade completed: _____
Degree(s): _____
Name of Institution: _____
Have you ever had difficulty with the following areas prior to your illness or accident? (circle all that apply)

Understanding Reading Speaking Writing
Math Attention Memory
Problem Solving

Work History

Currently Employed? Yes No Date of Retirement? _____
Occupation: _____
Place of Employment: _____
Job
Duties:_____
_____
__

Activities of Daily Living

Are you currently driving? Yes No

What are your household responsibilities? (circle all that apply)

Computer tasks Balancing Checkbook Grocery Shopping Cooking
Cleaning Child Care Yard Work Household
Repairs Laundry Driving Other: _____

Have you ever stopped doing any of your previous activities?
If yes, what and why?

_____
_____
_____

Please list any specific hobbies, interests, or social activities:

_____
_____
_____

Family History

Spouse's Name: _____

Children's Name:

_____ Age _____
_____ Age _____
_____ Age _____

Do you have any family history of speech/hearing problems? Yes No
Please explain: _____

_____
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Thank you for taking the time to complete this form.