

Adult Case History

General Information:

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Occupation: _____ Business Phone: _____

Employer: _____

Referred By: _____

Family Physician: _____ Phone: _____

Address: _____

Single ___ Widowed ___ Divorced ___ Spouse=s Name: _____

Children:

Name	Gender	Ages

Who lives in the home:

What language do you speak? If more than one, which on is your primary language?

Describe your speech-language problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Have you seen any other speech-language specialists? Yes___ No _____ If so, who and when?

Name: _____ Date: _____

What were their conclusions or suggestions?

Have you seen any other specialists (physicians, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist=s conclusions or suggestions.

Are there any other speech, language, learning, or hearing problems in your family? If yes, please describe.

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

List all medications you are taking.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you having any negative reactions to these medications? If yes, describe. _____

Describe any major accidents.

Provide any additional information that might be helpful in the evaluation or remediation process.

Medical History:

Please check if you have or have had any of the following:

Adenoidectomy	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>
Colds	<input type="checkbox"/>	High Fever	<input type="checkbox"/>
Coordination problems	<input type="checkbox"/>	Influenza	<input type="checkbox"/>
Croup	<input type="checkbox"/>	Mastoiditis	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>

Dizziness		Mumps	
Draining Ear		Noise Exposure	
Ear Infections		Seizures	
Emotional problems		Speech/Language problems	
Encephalitis		Substance Abuse	
German Measles		Tinnitus	
Headaches		Tonsillectomy	

Person completing forms: _____

Relationship: _____

Signed: _____ Date: _____