Adult Case History Form

General Information

Name:	Date of Birth:
Address:	Phone:
City:	Zip Code:
Occupation:	Business Phone:

Highest Degree Earned:
Employer:

Referred by:	Phone:

Address:

Family Physician:	Phone:

Address:

Check Marital Status:	Single	Widowed	Divorced	Spouse's Name

Children (include names, gender, and ages):
Who lives in the home?
What languages do you speak?
If more than one, which is the dominant language?

Do you have any problems with your hearing? If you have seen an audiologist or hearing aid specialist and had a hearing test, what were the results?

Describe any changes you have noticed in your voice. Does it sound weak or hoarse? Do people have trouble hearing you?

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 specialists (physicians, , psychologists, neurologists, etc.)? If yes, indicate the name of specialist, when you were seen, and the specialist's conclusions or suggestions.

_____
_____
_____
_____
_____
_____
_____

Does anyone else in your family have a speech or language problem? If yes, please describe.

_____
_____
_____
_____
_____
_____
_____
_____

Medical History

Provide the approximate year if you had any of the following illnesses and conditions:

Adenoidectomy/ Tonsillectomy	Asthma	
		Dizziness
	Ear infections	Encephalitis
German measles	Headaches	Hearing loss
High fever	Influenza	Mastoiditis
Measles	Meningitis	Mumps
Noise Exposure	Otosclerosis	Pneumonia
Seizures	Sinusitis	Stroke or other neurologic disorder
Surgery	Tinnitus	Other

Do you have any eating difficulties? Do you cough while drinking liquids or swallowing solid foods? If yes, please describe.

_____
_____
_____
_____
_____
_____

List all medications you are taking:

_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____

Describe any major surgeries, operations, or hospitalizations (include dates).

_____
_____
_____
_____

_____
_____

Describe any major accidents, and any significant changes that resulted.

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

Person completing form:	Relationship to client:
Signed:	Date: