

ADULT CASE HISTORY

To expedite treatment, please fill out this form as completely as possible.

Section 1 Client Demographics

Date:			
Name:		DOB:	Age: Gender: F M
Phone: home:	_ cell:	work:	
Best time to call:		Email:	
Address:			
City:	State:	Zip:	
Responsible Party:			Age:
Reason for referral:			
Referring person:			
Insurance Information			
Primary Insurance:	Polic	y/Group#	Phone#
Subscribers name:		DOB:	Relationship:
Secondary Insurance:	Polic	cy/Group#	Phone#
Subscribers name:		DOB:	Phone#
Place of Employment:		Employe	rs Phone#
Section 2 History of Problem			
Who lives in the home?			
What languages do you speak? If more	than one, which is you	r primary language?	
Describe your speech-language probler			
What do you think may have caused yo	ur problem?		

Have you seen any other speech-language specialist? Who and when? What were their conclusions or su Have you seen any other specialists (physicians, psychologists, neurologists, etc.)? If yes, indicate the typ you were seen, and the specialist's findings and recommendations. Is there a history or any other speech, language, learning, or hearing problems in your family? If yes, please Section 3 Medical History Please mark if you have had any of the following: Seizures High fevers Measles Chicken Pox Whooping cough Diphtheria Pneumonia Tonsilitis Meningitis Rheumatic fever Tuberculosis Sinusitis Enlarged glands Thyroid Asthma	alists (physicians, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when ist's findings and recommendations. peech, language, learning, or hearing problems in your family? If yes, please describe	Has the problem changed since it was	s first noticed?		
Section 3 Medical History Please mark if you have had any of the following: Seizures High fevers Measles Chicken Pox Whooping cough Diphtheria Pneumonia Tonsilitis Meningitis Sinusitis	ist's findings and recommendations. peech, language, learning, or hearing problems in your family? If yes, please describe ny of the following: High feversMeaslesEncephalitisWhooping coughDiphtheriaMumpsTonsilitisMeningitisBronchitisTuberculosisSinusitisChronic coldsThyroidAsthmaHeart troubleDiabetesHead injuriesHearing Loss	Have you seen any other speech-lang	juage specialist? Who and when	? What were their conclusions	or suggestions?
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Chronic LaryngitisDiabetesHead injuries	he relevant details (e.g. dates, how frequent and/or how severe are the episodes?):	Chronic Laryngitis	Diabetes	Head injuries	Hearing Loss
For items marked above, give the relevant details (e.g. dates, how frequent and/or how severe are the epi-		For items marked above, give the rele	evant details (e.g. dates, how free	quent and/or how severe are th	ne episodes?):

	- Danish a		
Recurrent earaches/ear infection	s? Describe:		
Are immunizations current?	Current a	eneral health?	
Allergies? (Describe)			
Any other serious or recurrent illn	nesses? / When?		
Any operations? / When?			
Hearing difficulties?			
f so, Aided?			
/ision problems?			
f so, treatment?			
Dental problems :			
Freatment:			
Dominant Hand: Right I	Left		
Section 4 Personal and Med	ical Information		
Personal Primary Physician:		Date of	of last visit:
Address or Location:			
Current Medications:	Dosage:	Physician:	Reason:

Chronic Health Problems (Asthma, Congenital Defects, etc.):	
Section 5 Educational and Vocational History	
Highest level of education:	
Diplomas or degrees:	
Future educational plans:	
Were you or are you satisfied with your academic performance?	Explain?
How did or does your communication difficulty affect your perforr	mance in school?
Occupation:	Employer:
How have communication difficulties affected the previous jobs y	rou have held?
Describe your current job setting and your communication needs	;

How do communication problems affect your current job?		
Does your communication difficulty affect your future job plans?		
Please use the following space to expound on previous sections or to tell us any other information you would like us to know:		

Confident Communication; Life-Changing Treatment

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