Adult Case History Form

Client Name: ___________________________________ Today's Date _______________
Date of Birth: ___________________ Age: ____________ Gender: __________________
Name of Person Completing Form (if other than client):_____________________________
Relationship to Client: _____________________________

Client's Primary Language(s): ☐English ☐Spanish ☐Other: ________________________
Client's Second Language(s): ☐English ☐Spanish ☐Other: __________________________

Client's Occupation: ____

How did you hear about us? ____

<u>Current Status</u>
Why are you seeking an evaluation by a speech-language pathologist?:
____
____
____
____

When did your communication or swallowing issues begin?
____
____
____

What do you think caused these issues? ____
____
____
____

Have you previously received speech, language or swallowing evaluation/treatment?
☐Yes ☐No Where?: ____________________________When?: ____________________
Describe the results: ____
____
____

Do your communication or swallowing difficulties impact your social life, work, or hobbies?
☐Yes ☐No Describe:____
____
____

What strategies do you use to help cope with these difficulties? ________________________
____
____

Medical History:
Describe any pertinent information regarding injuries, hospitalizations, surgeries, abnormalities, diagnoses, chronic illness, etc.: ____
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____

Please list all current medications: ____
____
____

Please list any allergies: ____
____

Check all that apply:

☐Asthma
☐Attention Deficit Disorder
☐Auto accident
☐Brain injury
☐Breathing problems
☐Cancer
☐Cardiac issues
☐Cleft palate
☐Cognitive issues
☐Degenerative illness
☐Depression
☐Developmental delay
☐Diabetes
☐Ear infections
☐Encephalitis
☐G-tube
☐Hearing loss
☐Pneumonia
☐Psychiatric issues
☐Respiratory problems
☐Reflux/GERD
☐Seizures
☐Stroke / TIA
☐Swallowing problems
☐Other

Is there anything else you feel it is important for us to know?___________________________
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____