Adults To Pediatrics Therapy, LLC

Speech, Language and Swallowing Therapy

ADULT CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION

Name:________________________ Date of Birth: ____________ Sex: ☐ Male ☐ Female

Address: ____
Daytime Phone: __________________ Home: ________________ Cell: ______________
E-Mail: ____

Contact Name: __________________ Address: ________________________________
Daytime Phone: __________________ Home: ________________ Cell: ______________
E-Mail: _______________________ Relationship to Patient:_________________________

Doctor's Name: ______________________ Phone: ____________ Fax: ______________

SOCIAL HISTORY

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: ________________________________

Children:

Name	Age
______________________________	______
______________________________	______
______________________________	______
______________________________	______

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one(s)?____

What is the patient's primary language? ________________________________

Who do you live with? ____

What is your profession? ____

Are you currently working? ☐ Yes ☐ No

Do you plan to return to work? ☐ Yes ☐ No

What is your highest level of education? __________________________________

What are your hobbies and interests? ____________________________________

How do you learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Other __________

MEDICAL HISTORY

Check any of the following that you have experienced:

- ☐ Allergies
- ☐ Sinus Infection
- ☐ Anemia
- ☐ Reflex
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Broken Nose
- ☐ Bronchitis
- ☐ Cancer/Tumors
- ☐ Cerebral Palsy
- ☐ Pneumonia
- ☐ Syphilis
- ☐ Chronic Colds
- ☐ Chronic Laryngitis
- ☐ Cleft Palate
- ☐ Dizziness
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Ear Disease/Infections
- ☐ Hearing Problems
- ☐ Facial Nerve Paralysis
- ☐ Emotional Difficulty
- ☐ Poliomyelitis
- ☐ Dental Problems
- ☐ Psychological Counseling
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Headaches
- ☐ Lung Problems
- ☐ Neurological Problem
- ☐ High Blood Pressure
- ☐ Thyroid Problem
- ☐ Heart Disease
- ☐ Head Injuries
- ☐ Rheumatic Fever
- ☐ Incoordination or weakness of face and/or tongue muscles
- ☐ High Fever
- ☐ Kidney Disorders
- ☐ Seizure Disorder
- ☐ Developmental Delay
- ☐ Lung Disease
- ☐ Influenza
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Meningitis/Encephalitis
- ☐ Scarlet Fever

Other serious injury/surgery: ____________________

Please explain any boxes checked above: ____________________

____

Are you currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? ____________________

____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe and include dates: ____________________

____

Have you had any testing done recently (e.g. x-rays, MRI)? ☐ Yes ☐ No

If yes, what were the results? ____________________

____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please describe and include dates: ____________________

____

Have you ever smoked? If yes, how many years ________ ☐ Yes ☐ No

Do you have a history of alcohol abuse? ☐ Yes ☐ No

Have you taken prescription/non-prescription drugs over the last year? ☐ Yes ☐ No

Explain: ____________________

____

Please list any medications you take regularly (prescription and non-prescription):

____

____

Have you had any other health problems? ☐ Yes ☐ No

Explain: ____

____

SPEECH-LANGUAGE-HEARING

Please describe the problem(s) for which you seek speech therapy: ______________________

____

____

Have you had the problem(s) before? ☐ Yes ☐ No

If yes, please describe: ____

____

Has the problem changed since it was first noticed? ☐ Yes ☐ No

If yes, please describe: ____

____

Have you ever received any treatment for this condition? ☐ Yes ☐ No

If yes, what type and where? ____

Have you ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? ____

What were you told? ____

Have you ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? ____

What were you told? ____

Have you ever had speech therapy? (If yes, please answer the following questions) ☐ Yes ☐ No

Where and when? ____

How often were you seen for therapy? ____________________________________

How long were you in therapy? ____

What were you working on? ____

____

Have you ever received any other evaluation or therapy (e.g. physical therapy, counseling, occupational therapy, vision)? ☐ Yes ☐ No

If yes, please describe: ____

Do you have a hearing problem? ☐ Yes ☐ No

In which ear? ☐ Right ☐ Left ☐ Both

When was the onset of your hearing loss? ____________________

Was the onset: ☐ Sudden ☐ Gradual

Has your hearing loss been gradually progressive in nature? ☐ Yes ☐ No

Does your hearing fluctuate from day to day? ☐ Yes ☐ No

What was the cause of your hearing loss? ____________________

Do you experience any sounds ("tinnitus") in your ears or your head? ☐ Yes ☐ No

Do you ever experience dizziness, balance problems or spinning sensations? ☐ Yes ☐ No

If yes, please describe: ____________________

Do you wear a hearing aid? ☐ Yes ☐ No

SWALLOWING HISTORY

Do you have trouble swallowing? (If yes, please answer the following questions) ☐ Yes ☐ No

When did the swallowing problem start? ____________________

Please describe in detail the nature of the swallowing problem: ____________________

____

Has the swallowing problem gotten better or worse? ☐ Yes ☐ No

If yes, please describe: ____________________

____

Does the swallowing problem happen with certain foods or liquids? (Please describe.) ____________________

____

Are you on a special or modified diet? ☐ Yes ☐ No

Does the swallowing problem happen at different times of the day? (Please describe.) ____________________

____

Have you had a swallowing study in the past? ☐ Yes ☐ No

If so, when? ____________________

What were the results? ____________________

COMMUNICATION SKILLS

Do you have difficulty speaking? ☐ Yes ☐ No

Do you have difficulty understanding what other people say? ☐ Yes ☐ No

Do you have difficulty reading? ☐ Yes ☐ No

Do you have difficulty writing? ☐ Yes ☐ No

Please describe your current communication difficulties: ____________________

____

Please describe how your communication difficulties have affected your daily life (e.g. work, relationships, hobbies): ____________________

Please describe how you communicate (e.g. words, gestures, writing): ______________________________

____

Please describe what you'd like to improve about your communication: __________________________

____

COGNITIVE SKILLS

Do you have difficulty with your memory? ☐ Yes ☐ No
Do you have difficulty paying attention? ☐ Yes ☐ No
Do you have difficulty with problem solving and reasoning? ☐ Yes ☐ No
Please describe your cognitive difficulties: ____

____

ADDITIONAL COMMENTS

____
____
____
____
____