Essence
Speech-Language Pathology Services

"What You Say Matters"

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ADULT CASE HISTORY

Please complete the following form and bring it to your scheduled evaluation.

Name:_____ Today's Date:_____
Physician:_____ Birthdate/Age:_____
Address:_____ Phone:_____
City/State/Zip:_____ Cell/Work:_____
Email:_____
Reason/Person for Referral: _____

_____

A. Background Information:

1. What are your current concerns regarding your speech, language, cognition swallowing, or motor skills?_____
_____
_____

2. What do you think caused the above difficulties?_____
_____
_____

3. When was the problem first noticed?_____
_____

4. Has the problem changed (worsened/ resolved) since it was first noticed? Describe.
_____
_____
_____

5. Have you ever seen a specialist/therapist regarding these difficulties? Who and when? NO What were their conclusions/recommendations? If so, do you have copies or may we obtain copies of progress and/or discharge reports?_____
_____
_____
_____

B. Medical History:

1. Do you currently have any medical diagnoses? If so, what are they?_____

_____

2. Have you ever had surgery or been hospitalized for any reason? If yes, please list and indicate approximate dates._____
_____
_____
_____
_____

3. Do you/ have you suffered from any illnesses or medical conditions? If yes, please list and indicate approximate dates._____
_____
_____

4. Are you currently taking any medications? Please list.
_____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

5. Do you have any known allergies? (medications, foods, latex, seasonal, etc.) Please list.
_____
_____
_____

6. Has your hearing been evaluated? If so, indicate where, when, and the status of that evaluation._____
_____

7. Has your vision ever been evaluated? If so, indicate when, where, and the status of that evaluation._____
_____

8. Do you use English as a second language? If so, what is your native language?
_____

9. Although an accent is not a disorder, do you find an accent is affecting your ability to communicate?_____

C. Family/ Social History:

1. Indicate current marital status: Single___ Widowed___ Divorced___ Married___ Spouse's Name if applicable:_____

   Emergency Contact (name/phone):
_____

2. Describe current or past occupation/employer:_____
_____

3. Highest grade, diploma, or degree earned._____

4. List any children (names, gender, and ages)_____
_____
_____

5. List who is currently living in your home and in what setting (i.e. 2-story house, 2nd floor apt, etc.)._____
_____
_____

6. Is there any family history of speech, language, learning, hearing, medical or mental health issues? Describe._____
_____
_____

7. List hobbies/interests:_____
_____

8. What is the best way you learn new things? Written instruction____ Demonstration____ Verbal instruction____ Hands-on learning____ Other: _____

D. Therapy History:

1. Have you ever received any type of therapy (speech/language, occupational, physical)? If, so indicate which type(s) and durations._____
_____
_____

2. If applicable, please list conditions treated in therapy. _____
_____
_____

E. Speech and Language Skills:

1. Do you have difficulty expressing your wants and needs? If yes, please explain._____
_____

2. Do others find you difficult to understand? If yes, please explain._____
_____

3. Do you find it hard to understand others? If yes, please explain._____
_____

4. Do you have short-term and/or long term memory difficulties? If yes, please explain.__
_____
_____

5. Do you have difficulty with word-finding (i.e. remembering the names of objects and/or people)? If yes, explain._____
_____

6. Do you have difficulty with reading or writing? If yes, please explain._____
_____

7. Has there been any changes to your voice (i.e. hoarse, breathy, loss of volume)? If yes, please explain._____

_____

F. Swallowing Skills:

1. Please indicate (check mark) if you have difficulty with any of the following:

____ Chewing Food
____ Drooling
____ Increased meal times
____ Moving food to the back of the mouth
____ Managing Liquids
____ Coughing
____ Choking
____ Holding cup/utensils
____ Watery Eyes
____ Clearing food/liquid from the mouth

2. Are you currently on a modified food and/or liquid diet? If yes, please explain._____
_____

3. Are their food/liquid textures that you avoid?_____

4. Do you currently wear dentures? Indicate full or partial._____

G. Activities of Daily Living:

1. Do you require assistance with any of the following?:
____ Dressing
____ Cooking
____ Eating
____ Telling Time
____ Housekeeping
____ Grocery Shopping.
____ Moving/Walking from place to place
____ Toileting
____ Transportation/Driving
____ Showering/Hygiene
____ Making Phone calls
____ Money Management/Paying Bills
____ Keeping track of appointments

2. Do you have any difficulties with fine motor skills to be able to manipulate clothing fasteners, utensils, opening jars, keyboarding, etc.? If yes, please explain._____
_____
_____

H. Therapy Goals:

1. What are your current speech/language related goals/expectations?_____

_____

_____

2. Do you wish to proceed with private speech therapy if needed?_____

3. If yes to #2, what are your preferred/available times for therapy?_____
_____

4. Are there any preferences or issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy?_____
_____

**Please provide any additional information that may be helpful to the evaluation/treatment process:_____
_____
_____

_____
Completed by: Date:

THANK YOU!