

Adult Case History Form

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

Name: _____

Physician: _____

Address: _____

City/State/Zip: _____

Email: _____

Reason/Person for Referral: _____

Today's Date: _____

Date of Birth: _____

Age: _____

Phone Number: _____

Cell/Work Number: _____

A. Background Information:

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

2. What was the cause of 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? 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: _____

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. _____

G. Swallowing Skills:

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

<input type="checkbox"/> Chewing Food	<input type="checkbox"/> Drooling	<input type="checkbox"/> Moving food to the back of the mouth
<input type="checkbox"/> Managing Liquids	<input type="checkbox"/> Increased meal times	<input type="checkbox"/> Watery eyes when eating/drinking
<input type="checkbox"/> Coughing	<input type="checkbox"/> Holding cup/utensils	<input type="checkbox"/> Clearing food/ liquid from the mouth
<input type="checkbox"/> Choking	<input type="checkbox"/> Other _____	

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. _____

H. Activities of Daily Living:

1. Do you require assistance with any of the following?:

<input type="checkbox"/> Dressing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Money Management/ Bill Payments
<input type="checkbox"/> Cooking	<input type="checkbox"/> Transportation/ Driving	<input type="checkbox"/> Keeping track of appointments
<input type="checkbox"/> Eating	<input type="checkbox"/> Showering/ Personal Hygiene	<input type="checkbox"/> Moving/ walking from place to place
<input type="checkbox"/> Telling Time	<input type="checkbox"/> Making phone calls	<input type="checkbox"/> Grocery Shopping
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Other _____	

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. _____

I. Therapy Goals:

1. What are your current speech/language related and/or occupational therapy goals/expectations? _____

2. Do you wish to proceed with speech/swallowing therapy? _____

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

4. Are there any 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 _____ on _____ (date).

THANK YOU!