ADULT - CASE HISTORY FORM

Name: _____ Date of Birth: _____
Address: _____
Phone: _____
Occupation: _____
Referred by: _____
Family Physician: _____
Phone: _____ Address:_____
Are you: □ Single □ Windowed □ Divorced □ Married
-Spouse's Name: _____
Children: (include their name, gender and age)
_____
_____
Who lives in the home?_____
_____
What language(s) do you speak? Which is your dominant language?
_____
_____

GENERAL INFORMATION
Describe your speech-language problem.
_____
_____
_____
_____
_____
What do you think may have caused the problem?
_____
_____
_____
_____
Has the problem changed since it was first noticed? How? □ Yes □ No
_____
_____
_____
_____

Have you seen any other speech-language specialists? □ Yes □ No
If Yes, When and for how long?_____

What were their conclusions or suggestions?

Have you received any speech therapy while homebound? θ Yes θ No Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc)? θ Yes θ No If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

Are there any other speech, language or hearing problems in your family?
□ Yes □ No If yes, please describe:

MEDICAL HISTORY

Do you have any eating or swallowing difficulties? θ Yes θ No If yes, please describe:

List all medications you are taking.

Are you having any negative reactions to these medication? □ Yes □ No
If yes, please describe:

Describe any major surgeries, operations or hospitalizations and when they occurred.

_____
_____
_____
_____
_____

Describe any major accidents and when they occurred.

_____
_____
_____
_____
_____

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation process.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Person completing form: _____
Relationship to patient: _____
Signature: _____ Date: _____

Please return this packet of information by mail prior to the evaluation, if possible, so the therapists can review and prepare the necessary evaluation. If it is not possible to return these prior to the evaluation, please bring them with you on the day of the evaluation.

Insurance Information **Please provide a copy of your medical insurance card(s) to the receptionist.**

Patients Name: _____Date of Birth: ____/____/_____

Primary Insurance

Name of Policy Holder: _____ DOB
___/___/_____ Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work
Phone: (____)_____ Insurance
Company_____
ID#_____ Group #_____ Ins
Co Address: _____City:_____State:____Zip_____
Ins Co. Phone: _____

DO YOU HAVE ANY ADDIONAL INSURANCE? □ Yes □ No IF YES, COMPLETE THE FOLLOWING SECONDARY INSURANCE INFORMATION.....

Secondary Insurance

Name of Policy Holder: _____ DOB
___/___/_____ Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work
Phone: (____)_____ Insurance
Company_____
ID#_____ Group #_____ Ins
Co Address: _____City:_____State:____Zip_____
Ins Co. Phone: _____