ACCESS
SPEECH THERAPY

ADULT CASE HISTORY FORM

Name: _____**Date of birth**: _____

Address: _____**Phone**: _____

_____

Email (optional): _____

Occupation _____

Family physician: _____

Referring physician: _____

Person filling out this form (circle one): self other: _____

What is your primary language? What other language do you speak? _____

Describe your current speech, language, or swallowing issue _____

_____

_____

Does this speech-language difficulty impact your ability to function in daily life? _____

How or where does the speech-language difficulty impact you the most? _____

_____

Describe your daily communication needs: _____

_____

What do you hope to get out of speech-language therapy? _____

_____

Medical history: please check all that apply. Please provide the dates where applicable

- ☐ Heart attack
- ☐ Heart troubles
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Chronic laryngitis
- ☐ Acid reflux
- ☐ Ear infections
- ☐ Meningitis
- ☐ Seizures
- ☐ Head injury
- ☐ Neurological conditions
- ☐ Allergies
- ☐ Cancer
- ☐ Head/neck cancer
- ☐ Shingles
- ☐ Bronchitis
- ☐ COPD
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Arthritis
- ☐ Hearing loss
- ☐ Cerebral palsy
- ☐ Intellectual deficits
- ☐ Cleft palate
- ☐ Chronic colds
- ☐ Facial nerve palsy
- ☐ Emotional or psychological issues
- ☐ Multiple sclerosis
- ☐ Huntington's or Parkinson's Disease
- ☐ Voice issues or changes
- ☐ Vocal polyps or nodules

What is your current state of health?

- ☐ Excellent
- ☐ Average-fair
- ☐ Poor

Have you been hospitalized within the last 5 years? If so, why? Where?

Please list any medications you are taking at this time:

Do you use any of the following assistance devices?

- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Other
- ☐ None

Are you able to climb stairs: _____ Yes _____ No

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

Are there any other difficulties besides what is listed above? _____

When was the problem first noticed? _____

Did the problem begin suddenly or develop over time? _____

Have you been seen by any other rehabilitation professionals? _____

☐ **Speech therapy**: where: _____ when: _____

☐ **Physical Therapy**: where: _____ when: _____

☐ **Occupational Therapy**: where: _____ when: _____

☐ **Other**:

SOCIAL AND EDUCATIONAL HISTORY

1. Marital Status:

☐ Single ☐ Divorced

☐ Married ☐ Widowed

2. Spouse or partner's name: _____
3. Children:

Names	Ages

4. Occupation: _____

Do you currently work? _____ YES _____ NO

5. Employer: _____

6. Highest level of education (grade or degree) completed.

_____

Please provide other information you believe to be helpful in the development of your care here with us at ACCESS Speech Therapy, Inc.. Thank you

_____

Patient signature Date