

PATIENT INFORMATION (ADULT)

Name: _____ Date of Birth: _____

Address: _____
(Include city and zip code)

Email address: _____

Phone:
(Home) _____ (Cell): _____

(Work): _____

Emergency Contact

Name: _____ Phone: _____

Attending Physician's Name: _____

Physician's Address: _____

City: _____ Zip: _____

Do you have a prescription from your physician? Yes No

Do you have a referral from another therapist? Yes No

How did you find us? (Please Circle)

Physician Friend Insurance Internet School Other _____

Person Responsible for Payment:

Name: _____ Phone: _____

Address: _____ Zip: _____

SSN: _____

Adult Case History

General Information

Patient Name: _____ Date of Birth: _____

Occupation: _____

Person Completing Form: _____ Relationship to Patient: _____

Marital Status: Single Widowed Divorced

Spouse's Name: _____

Highest grade, diploma, or degree earned by patient: _____

Describe your current concerns: _____

Have you been seen by any other medical or therapy specialists? (i.e. SLP, OT, PT, Neurology, Oncology, Psych, etc); If so, please list below and provide records if you have them.

Is there a history of speech or cognitive difficulties in your family? If so, please describe:

Medical History

Please check if you have experienced any of the following; please provide the year of diagnosis, if possible:

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Head/Neck Cancer	<input type="checkbox"/> Facial nerve palsy
<input type="checkbox"/> Heart problem	<input type="checkbox"/> COPD	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Huntington's Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Chronic laryngitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tremor
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Respiratory difficulties	<input type="checkbox"/> Voice issues or changes
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Thyroid issues	<input type="checkbox"/> Vocal polyps or nodules
<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anxiety or depression
<input type="checkbox"/> Head injury	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Handwriting difficulties
<input type="checkbox"/> Neurological impairment	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Memory difficulties
<input type="checkbox"/> Allergies	<input type="checkbox"/> Intellectual/learning disabilities	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cleft palate	<input type="checkbox"/> Other:

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

List all medications and vitamins you are currently taking:

Additional History - Please read and fill out the table below:

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Memory			
Problem-solving			
Focusing/Attention			
Reading/Writing			
Finding words or getting the right words out			
Maintaining topic of conversations			
Speech difficulties (i.e. how you sound)			
Following directions			
Difficulties with dressing yourself			
Difficulties completing daily tasks			

Are there things you were able to do previously that you cannot do now? Please describe:

How does what you listed above impact your ability to function in daily life? Please describe:

When was the problem first noticed? Suddenly, or over time? Please describe:

Is there anything else you would like to share with us to better support you?
