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

Do you have a referral from another therapist? Yes

How did you find us? Please select

Physician Referral Name: _____ Other Referral:_____

Person Responsible for Payment:

Name: _____ Phone_____

Address: _____

City: _____ State: _____ Zip: _____

Adult Case History

General Information

Patient Name: _____ Date of Birth: _____

Occupation: _____

Person Completing Form: _____ Relationship to Patient: _____

Marital Status: ☐ Married ☐ 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:

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