

Adult Case History

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Patient Information

Date: _____

Patient's Name: _____ Age: _____

Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ E-mail: _____

Cell Phone: _____ Work Phone: _____

Occupation: _____

Employer: _____

Employer's address: _____

Single __ Widowed __ Divorced __ Married __ Other __

Spouse's Name _____

Children (include names, sex, and ages):

Who lives in the home? _____

What languages do you speak? If more than one, which one is your primary language? _____

Existing Diagnosis: _____

Referred by: _____

How did you hear about us? _____

Patient's Primary Physician's Name: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Concerns

Describe the problem for which you are referred and your concern as it relates to your speech, language, voice: _____

What do you think may have caused the problem? _____

When did you first notice the problem? _____

Has the problem changed since it was first noticed? _____

Have you seen any other speech-language specialists? Who and when? What were the results? _____

Have you seen any other specialist (physicians, psychologists, neurologists, etc.)? If yes, indicate the name, type of specialist, etc. _____

Are there any other speech, language, learning, voice, or hearing problems in your family? If yes, please describe: _____

Medical History

Please check any of the following illnesses and conditions you may have had and provide the approximate age:

Asthma _____ Chicken Pox _____ Convulsions _____ Frequent colds _____

Hearing loss _____ Ear infections _____ Noise exposure _____ Otosclerosis _____

Seizures _____ High fever _____ Tonsillitis _____ Sinusitis _____

Allergies _____ To what? _____

Other _____

Do you have any eating or swallowing difficulties? If yes, describe: _____

List medications you are taking: _____

List any major surgeries, operations, or hospitalizations and dates they occurred: _____

List any major accidents and when they occurred: _____

Please provide any additional information that may be helpful in the evaluation or therapy process: _____

Please return this form along with copies of any previous evaluations, or other reports you would like us to consider.

Thank you!