Adult Case History Form

General Information:

Name: ______________________ Date of Birth: _________ Age: __ Pronouns: ______

Address: ____
(Street) (City/State/ZIP)

Phone Number: _______________________ Alt. phone number: __________________

E-mail Address: ____

Preferred Method of Communication (call, text, e-mail): _______________________

Employment:

- ☐ Full-Time
- ☐ Part-Time
- ☐ Student
- ☐ Other: ______________________________________

Place of Employment/School: ____

Position Title: ____

Medical History:

Primary Physician’s Name: ____

Primary Physician’s Phone Number: ______________________________________

Please list any serious injuries, illnesses, hospitalizations, surgeries, neurological events, physical handicaps, or other medical information that you think may be relevant. Please give dates/years for each event:

____
____
____
____
____
____

Please list any medications taken:

Medication:	Frequency/Dose:	Reason:

Do you currently see any other specialists (e.g. physical therapist, occupational therapist, psychologist, psychiatrist, ENT, neurologist)? If yes, please list below:

Type of Service:	Specialist

Have you received any services in the past for counseling, speech, physical, or occupational therapy? Please list below:

Type of Service:	Specialist:	Dates:

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When/where was your most recent hearing test? ______________________________

Describe any hearing difficulties: ____

When/where was your most recent vision test? ________________________________

Describe any vision difficulties: ____

List any food or environmental allergies:

____

____

____

____

Describe any difficulties with eating, chewing, or swallowing:

____

____

____

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Home Information:

I live with my:

- ☐ Spouse
- ☐ Children
- ☐ Parent(s)
- ☐ Roommate(s)
- ☐ Alone
- ☐ Other: ____

Please list all persons who live with you:

Name:	Age:	Relationship to You:

Do you have any pets? Please list names and types:

____

____

Are there family circumstances that would be helpful to share with your therapist? (e.g. safety/legal):

____

____

____

____

Do you speak any languages other than English? If yes, how often?

____

____

____

Do any family members have a history of communication or related disorders? (e.g. speech, language, ADHD, autism)?:

Disorder type:	Relationship to you:

Current Concerns:

Statement of the problem (In your own words, what difficulty are you having?):

____
____
____
____

When was the problem first noticed?: ____________________________________

Who first noticed the problem? ____

Does the problem vary? Is it better or worse at certain times?:

____
____
____

How do you react to your problem?

- ☐ I revise/try again
- ☐ I give up
- ☐ I get angry/frustrated
- ☐ I don't notice the problem
- ☐ Other: ____

Has your physician noticed your communication concerns? If so, what have they recommended?

____
____
____
____

Have you been evaluated for speech/language in the past? If yes, when, where, and what were the findings?:

____
____

What questions would you like to have answered by this evaluation?

____
____
____
____

Personality Information:

Describe your strongest skills and traits? What makes you unique?:

____

____

____

List your favorite activities/hobbies:

____

____

List your favorite stores:

____

List your favorite books:

____

List your favorite movies:

____

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Emergency Contact Information:

Full Name: ______________________________ Pronouns: _____ DOB: ________

Phone Number: _____________________ Alt. Phone Number: _______________

Address: ____
(Street) (City/State/ZIP)

E-mail Address: ____

Relationship to Person: ____

May I discuss your treatment with this person? (YES/NO): _________________

____

Name: ______________________________________ Date: __________________

Signature: ____

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