# ADOLESCENT AND ADULT CASE HISTORY FORM

Name_____

Date of Birth _____Age_____M__F__
Address_____

Home Phone _____

Cell Phone_____

Email_____

Occupation_____

Business Phone_____
Employer_____

Employer's Address _____

Referred by_____

Primary Care Physician _____

Phone_____

Address_____

Marital Status: Single __ Widowed __ Divorced __ Married __

Other_____

Spouse's Name_____

Children (include name, sex, and ages):
_____
_____
_____

Who lives in the home?
_____

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

What was the highest grade completed, diploma or degree earned?

_____

Describe the problem for which you are referred and your concern as it relates to your speech, language, feeding, swallowing and/or voice difficulties:

_____
_____
_____
_____
_____
_____
_____

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 specialist? 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, when you were seen, and the specialist's conclusions or suggestions.

_____
_____
_____
_____

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:

Chicken Pox ____ Ear infections ___ High fever _____

Convulsions _____ Frequent colds_____

NoiseExposure_____
Otosclerosis_____Tonsillitis _____
Sinusitus _____

Allergies to what?_____

Asthma_____ Hearing loss_____ Seizures_____

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:

_____
_____
_____
_____