Stirling Speech Pathology

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You are scheduled for a speech/language evaluation on ___________ at ________am/pm.

SPEECH PATHOLOGY ADULT CASE HISTORY FORM

Name: ____**Date of birth**: ________________

Address: ____

Phone: (Home)_______________________ Phone: (Mobile)___________________________

Email (optional): ____

Occupation ____

General Practitioner: ____

Referring doctor (if appropriate): ____

Person filling out this form (circle one): self other: ______________

What do you hope to get out of speech therapy?

____

____

____

What is your primary language? ____

What other language do you speak?____

____

Medical history: please check all that apply. Please provide the dates where applicable

- ☐ Heart attack
- ☐ Heart troubles
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Chronic laryngitis
- ☐ Acid reflux
- ☐ Ear infections
- ☐ Meningitis
- ☐ Seizures
- ☐ Head injury
- ☐ Neurological conditions
- ☐ Allergies
- ☐ Cancer
- ☐ Head/neck cancer
- ☐ Shingles
- ☐ Bronchitis
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Arthritis
- ☐ Hearing loss
- ☐ Cerebral palsy
- ☐ Intellectual deficits
- ☐ Cleft palate
- ☐ Chronic colds
- ☐ Facial nerve palsy
- ☐ Emotional or psychological issues
- ☐ Multiple sclerosis
- ☐ Huntington’s or Parkinson’s Disease
- ☐ Voice issues or changes
- ☐ Vocal polyps or nodules

What is your current state of health?

- ☐ Excellent
- ☐ Average-fair
- ☐ Poor

Have you been hospitalized within the last 5 years? If so, why? Where? ___________________________

____

____

Please list any medications you are taking at this time:____

____

____

Do you use any of the following assistance devices?

☐ Wheelchair ☐Walker ☐Cane

☐Other ☐None

Are you able to climb stairs? YES NO

SPEECH-LANGUAGE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

Are there any other difficulties besides what is listed above? ______________________________

____

____

When was this problem first noticed?____

Did the problem begin suddenly or develop over time?_________________________________

____

____

Have you been seen by any other rehabilitation professionals?

- ☐ **Speech therapy**: where: ________________________ when: __________________
- ☐ **Physiotherapy**: where: _________________________ when: _________________
- ☐ **Occupational Therapy**: where: ________________________ when: ________________
- ☐ **Other**: ____

Does this speech-language difficulty impact your ability to function in daily life?_____________

____

____

____

How or where does the speech-language difficulty impact you the most?__________________

____

____

____

Describe your daily communication needs: ____

____

____

____

SOCIAL AND EDUCATIONAL HISTORY

1. Marital Status:

☐ Single ☐ Divorced

☐ Married ☐ Widowed

2. Spouse or partner's name: ___________________________________

3. Children:

Names	Ages

4. Occupation: ____

Do you currently work? YES NO

5. Employer: ____

6. Highest level of education (grade or degree) completed.

____

____

Please provide any other information you believe to be helpful in the development of your care here with us at Stirling Speech Pathology.____

____

____

Do you give your consent for the clinic to contact other professionals involved in your management to enable us to get a full picture? YES NO

If Yes, please specify who you believe could provide additional information: ________________

____

____

Patient/Carer signature:____________________________________Date:___________________