

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Intellectual deficits, MR |
| <input type="checkbox"/> Heart troubles | <input type="checkbox"/> Head/neck cancer | <input type="checkbox"/> Cleft palate |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shingles | <input type="checkbox"/> Chronic colds |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Facial nerve palsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> COPD | <input type="checkbox"/> Emotional or psychological issues |
| <input type="checkbox"/> Chronic laryngitis | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Huntington's or Parkinson's Disease |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Voice issues or changes |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Vocal polyps or nodules |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid issues | |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Neurological conditions | <input type="checkbox"/> Hearing loss | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cerebral palsy | |

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: _____