# Adult Case History

*Please fill out this form as completely as possible. If you need more space, attach another page.*

**Thank you for taking the time to fill out these forms. Complete case history forms are essential to receiving a thoughtful and well-designed evaluation. By sending these completed forms to our office at least TWO DAYS PRIOR to your appointment we are able to best determine how to maximize our time with you. We look forward to meeting you.**

Date:_____

**I. GENERAL INFORMATION**

Patient Name:_____ Date of Birth: _____

Primary Care Physician:_____ Phone:_____
Address:_____ Fax:_____
_____ Email: _____
Referring Physician (if different): _____ Phone:_____
Address:_____ Fax:_____
_____ Email: _____

Handedness: ___Left ___Right ___Ambidextrous
Occupation(s):_____ Part time/ full-time/ unemployed/ retired/ disabled?
_____ Part time/ full-time/ unemployed/ retired/ disabled?
What is your native language?_____
List any additional languages you speak:_____

**II. HISTORY OF THE PROBLEM**

1. Briefly describe your reasons for seeking an evaluation?:_____
   _____
   _____
2. What symptoms are you currently experiencing? _____
   _____
3. When did these symptoms begin?_____
   _____

4. Have your symptoms changed since you first noticed them? _____
   _____
5. Have you been to any other specialists in relation to these symptoms? Please list the results of any testing you have undergone:_____
   _____
6. List any other referrals or recommendations that have been made: _____
   _____
7. Do you have a family history of speech, language, voice, cognition or hearing problems (Please specify)? _____
   _____

**III. SPEECH AND LANGUAGE**

1. Have you ever had difficulty with understanding language or with expressing yourself? If so, please describe:_____
   _____
   _____
2. What are your communication needs in social settings?_____
   _____
   _____
3. What difficulty do you have meeting your communication needs? _____
   _____
   _____
4. Have you ever had any of the following Communication Disorders (check all that apply):

| | | |
|---|---|---|
| ___Aphasia | ___Traumatic Brain Injury | ___Right Hemisphere Disorder |
| ___Articulation Disorder | ___Stuttering | ___Hearing Impairment |
| ___Voice Disorder | ___Dysarthria | ___Apraxia |

5. If yes, did you receive therapy/treatment? Please indicate where, when, and the duration of treatment:_____
   _____

**IV. SWALLOWING AND VOICE**

1. Do you cough or choke while eating or just after a meal? If yes, please describe nature and frequency: _____
   _____
2. Does it take multiple swallows to get food down? _____
3. Have you ever had pneumonia? If, yes, lists date(s): _____
4. How long does it take to finish a meal? _____
5. Please check if you currently have any of the following symptoms related to your voice **(check all that apply)**:

___no voice at all
___whisper only
___trouble speaking loud
___trouble speaking soft
___raspy voice quality
___scratchy voice quality
___voice seems to low
___voice seems to high
___unsteady/shaky voice
___voice breaks
___frequent throat-clearing
___pain in throat/throat irritation
___effortful voicing/strain
___voice fatigues easily
___nasality
___stuffed-nose quality
___tickling sensation in throat
___frequent dry throat
___breathy-weak tone
___lump in throat
___frequent coughing
___throat "clicks" or "hiccups"
___other:_____

**V. MEDICAL HISTORY**

1. Please check any conditions you currently have or have had in the past:

___High blood pressure
___Low blood pressure
___Heart disease
___Stroke
___Heart Attack
___Tuberculosis
___Asthma
___Bronchitis
___Pneumonia
___COPD
___Kidney Disease
___Urinary Problems
___Myasthenia Gravis
___Parkinson's Disease
___Multiple Sclerosis
___ALS (Lou Gherig's Disease)
___Seizures
___Meningitis
___Lupus
___Diabetes
___Thyroid Disease
___Endocrine Disorder
___Hypoglycemia
___Arthritis
___Aids or other immunologic disorder
___Cancer
___Syphilis
___Sinus problems/Sinusitis
___Cleft Palate
___Medically diagnosed depression
___Other:_____
_____
_____
___**NONE**

___Head Injury
___Whiplash
___Injury to neck or chest
___Ulcers
___Gastroesophageal reflux
___Hiatal hernia

2. Indicate other medical procedures you have had (check all that apply):

___Tonsillectomy
___Adenoidectomy
___Appendectomy
___Heart Surgery
___Oral Surgery
___Tracheotomy
___Lung Surgery
___Hysterectomy
___Thyroid Surgery
___Radiation (Specify:_____)
___Other (Specify:_____)
___**NONE**

3. What medications are you taking? List each medication and the reason you take it. Be sure to include over the counter products (e.g. Aspirin, Advil, Mylanta, Multivitamin, Fish Oil).

| | **MEDICATION** | **CONDITION** |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |

3. _____ _____

4. Do you have any hearing, vision, or physical disabilities (Please specify)? _____
_____

5. Please list any allergies you have (food, medication, environmental, latex): _____
_____

6. Please check if you have/have had any of the following symptoms:

___Bad breath first thing in the a.m.
___Hoarseness first thing in the a.m.
___Night coughing that interrupts sleep
___Frequent upset stomach
___Bitter acid taste
___Sleep on right side

___Heartburn
___Hiatal hernia
___Burping
___Antacid use
___Eat close to bed time
___Eat spicy foods

___Post nasal drip with allergies
___Bowel irregularity
___Frequent dry mouth or throat
___Change in skin or hair
___Very dry skin
___Hair loss

___Jaw pain or tension
___Neck pain or tension
___Shoulder pain or tension
___Abdominal pain
___Ear pain
___Nasal regurgitation

___Confusion/loss of consciousness
___Weakness/paralysis of face
___Clumsiness in arms or legs
___Numbness
___Tingling
___Headaches
___Hearing Loss

___Shaking or tremors
___Choking
___Difficulty swallowing
___Blurred vision
___Shortness of breath
___Insomnia
___Dizziness/Vertigo

___Easily chilled
___Hypersensitivity to temperature
___Easily fatigued
___Excessive sweating
___Night Sweats
___Weight gain
___Weight loss

___Stress
___Depression
___Emotional difficulty
___Personality change
___Memory Change
___Other: _____
___**NONE**

Please list, if known, any additional testing you have had or have scheduled to help diagnose your current problem (ex: neurological evaluation, CT scan, MRI, modified barium swallow):

_____
_____
_____
_____
_____

**IV. VOCATIONAL HISTORY**

1. How have your communication difficulties affected the types of jobs you have had?_____
   _____
2. Describe your current job setting and your communication needs in that setting: _____
   _____
3. How do communication problems affect your performance at your current job? _____
   _____
4. Does your communication difficulty affect your future job plans? _____ Explain: _____
   _____

**V. EDUCATIONAL HISTORY**

Schools attended:_____
Diplomas/Degrees:_____
Future Educational plans:_____

1. Were you, or are you satisfied with your academic performance?_____ If not, why? __
   _____
2. If you are in school, how does you communication difficulty affect your academic performance and social life in school? _____
   _____

**VI. ADDITIONAL INFORMATION**

Hobbies:_____
_____
Social/civic groups to which you belong: _____
_____
Other information you would like us to know: _____
_____
_____