SUMMIT INC SPEECH THERAPY

ADULT CASE HISTORY

To expedite treatment, please fill out this form as completely as possible.

Section 1 Client Demographics

*Date:*_____

*Name:*_____ *DOB:*_____ *Age:*_____ *Gender: F M*

*Phone: home:*_____ *cell:*_____ *work:*_____

*Best time to call:*_____ *Email:* _____

*Address:*_____

*City:*_____ *State:*_____ *Zip:*_____

*Responsible Party:*_____ *Age:*_____

*Reason for referral:*_____

_____

*Referring person:*_____

Insurance Information

Primary Insurance:_____ Policy/Group#_____ Phone#_____

Subscribers name:_____ DOB:_____ Relationship:_____

Secondary Insurance:_____ Policy/Group# _____ Phone# _____

Subscribers name:_____ DOB: _____ Phone#_____

Place of Employment:_____ Employers Phone#_____

Section 2 History of Problem

Who lives in the home? _____

_____

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

_____

Describe your speech-language problem. _____

_____

_____

What do you think may have caused your problem? _____

_____

_____

Has the problem changed since it was first noticed? _____

_____

Have you seen any other speech-language specialist? Who and when? What were their conclusions or suggestions? _____

_____

_____

_____

Have you seen any other specialists (physicians, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's findings and recommendations.

_____

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Is there a history or any other speech, language, learning, or hearing problems in your family? If yes, please describe._____

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Section 3 Medical History

Please mark if you have had any of the following:

____ Seizures	____High fevers	____Measles	____Encephalitis
____Chicken Pox	____Whooping cough	____Diphtheria	____Mumps
____Pneumonia	____Tonsilitis	____Meningitis	____Bronchitis
____Rheumatic fever	____Tuberculosis	____Sinusitis	____Chronic colds
____Enlarged glands	____Thyroid	____Asthma	____Heart trouble
____Chronic Laryngitis	____Diabetes	____Head injuries	____Hearing Loss

For items marked above, give the relevant details (e.g. dates, how frequent and/or how severe are the episodes?): _____

_____

_____

_____

Recurrent earaches/ear infections?_____ Describe:_____

Are immunizations current?_____Current general health? _____

Allergies? (Describe) _____

Any other serious or recurrent illnesses? / When? _____

Any operations? / When? _____

Hearing difficulties?_____

If so, Aided?_____

Vision problems?_____

If so, treatment? _____

Dental problems :_____

Treatment: _____

Dominant Hand: Right Left

Section 4 Personal and Medical Information

Personal Primary Physician:_____ Date of last visit:_____

Address or Location:_____

Current Medications: **Dosage:** **Physician:** **Reason:**

Chronic Health Problems (Asthma, Congenital Defects, etc.):_____

Section 5 Educational and Vocational History

Highest level of education:_____

Diplomas or degrees:_____

Future educational plans:_____

Were you or are you satisfied with your academic performance?_____ Explain?_____

How did or does your communication difficulty affect your performance in school?_____

Occupation:_____ Employer:_____

How have communication difficulties affected the previous jobs you have held?_____

Describe your current job setting and your communication needs:_____

How do communication problems affect your current job?_____

_____

_____

_____

Does your communication difficulty affect your future job plans?_____

_____

_____

Please use the following space to expound on previous sections or to tell us any other information you would like us to know:

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