19465 Deerfield Ave.
Suite 201
Lansdowne, VA 20176

BlueRidge SPEECH & HEARING

703-858-7620 (Voice/TDD)
703-858-7657 (fax)
www.speechhearing.org

ADULT CASE HISTORY FORM

Please fill out this form as completely as possible. The information will help us understand your present communication problem(s) and will aid us in planning appropriate testing procedures. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PLEASE NOTE: AFTER COMPLETION of this form, , PLEASE RETURN, ALONG WITH ANY PERTINENT MEDICAL REPORTS (e.g. Hospital discharge summaries, Neurological reports) TO THE CENTER AT LEAST (1) WEEK BEFORE THE SCHEDULED EVALUATION

Client Name: _____ Date: _____

Person completing this form if different from client (name/relationship): _____

Date of Birth: ___/____/____ Age: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____

Work: _____

E-mail: _____ Marital Status: M S W D Remarried

Do you have children? If so, please include names and ages: _____

_____

Please list all those living in the same household as yourself: _____

_____

Ethnicity: African American Asian Caucasian Hispanic/Latino Other_____

Place of Birth: _____

Native Language: _____ Other Languages Spoken: _____

Are you presently employed? Y N If YES, please list # hours worked per week: _____

Please list current or prior occupation (if retired): _____

Briefly describe your job duties: _____

Highest level of education completed: _____

School presently attending, if applicable: _____

How did you hear about this Center? _____

Name of person filling out questionnaire: _____

Relationship to client, if other than client: _____

Are you currently driving? Y N

General complaint (why are you coming to see us?) _____

19465 Deerfield Ave.
Suite 201
Lansdowne, VA 20176

BlueRidge SPEECH & HEARING

703-858-7620 (Voice/TDD)
703-858-7657 (fax)
www.speechhearing.org

Does this complaint interfere with your ability to do your job or engage in activities prior to the complaint? Y N If YES, please explain: _____

_____

MEDICAL INFORMATION

What symptoms/problems led you to request this evaluation? _____

_____

_____

What do you think may have caused the problem? _____

_____

Date of onset (*month, day, year* problem was first noticed): _____

Has the problem changed since it was first noticed (e.g. improved or worsened)? _____

_____

Have you ever been treated for this problem before? Y N

If YES, where and when? _____

If YES, what were the recommendations? _____

Was the treatment/therapy successful? Y N

Are you presently or have you in the past seen any other specialist(s) for this problem (physicians, audiologists, psychologists, neurologists, surgeons, physical therapist, etc)? Y N

If YES, please list each specialist's name, address, type of specialty and results or recommendations: _____

_____

_____

Do you have a history or are you currently experiencing:			COMMENTS/Dates
➢ Stroke/TIA	Y	N	_____
➢ Head Trauma/Concussion	Y	N	_____
➢ Falls/Injuries	Y	N	_____
➢ Allergies/Sinusitis	Y	N	_____
➢ Severe headaches/Migraines	Y	N	_____
➢ Facial Numbness	Y	N	_____
➢ Eating/Swallowing Difficulties	Y	N	_____

19465 Deerfield Ave.
Suite 201
Lansdowne, VA 20176

BlueRidge SPEECH & HEARING

703-858-7620 (Voice/TDD)
703-858-7657 (fax)
www.speechhearing.org

- Bronchitis or Pneumonia Y N _____
- COPD, asthma or other Breathing difficulties Y N _____
- Seizures Y N _____
- TB, Meningitis, Diphtherias Y N _____
- Heart conditions or Diseases Y N _____
- Hypertension Y N _____
- Reflux/Heartburn Y N _____
- Anemia Y N _____
- Encephalitis Y N _____
- Hoarseness/Vocal Fatigue Y N _____
- Physical Handicaps Y N _____

Have you had any Hospitalizations/Surgeries? Y N

Please list and provide dates:

Illness/Procedure	Date
_____	_____
_____	_____
_____	_____

Please complete this chart regarding any medication that you are currently taking (use back of page if necessary)

Medication	Dosage	Frequency of Administration	Reason for Meds

Please describe any side effects you may be experiencing as a result of taking medications listed above: _____

_____

19465 Deerfield Ave.
Suite 201
Lansdowne, VA 20176

BlueRidge SPEECH & HEARING

703-858-7620 (Voice/TDD)
703-858-7657 (fax)
www.speechhearing.org

Please indicate the date of your last Hearing Evaluation: _____

Do you currently wear hearing aids? Y N

Please indicate the date of your last Vision Test: _____

Do you currently wear glasses? Y N

Please describe any problems with your teeth, tongue, mouth, ears, nose, or throat:

_____

_____

Are you right- handed or left- handed? _____

SPEECH-LANGUAGE INFORMATION

Please rate the following symptoms on a scale of 1-5 (1being NEVER and 5 being FREQUENTLY)

Choking/coughing while eating __
Stuttered speech __
Slurred speech __
Word finding difficulties ___
Difficulty expressing thoughts __
Difficulty processing information __
Difficulty with time management __
Difficulty with reading __

Difficulty maintaining conversation __
Difficulty with focus/attention __
Memory difficulty __
Difficulty with problem solving __
Disorientation __
Difficulty with making good judgments __
Difficulty with organization __
Difficulty with writing __

Have you received speech therapy for any of the above problems? Y N

If YES, where and when? _____

_____

Have these problems regressed or improved since onset? _____

What do you hope will be the outcome of therapy? _____

_____

19465 Deerfield Ave.
Suite 201
Lansdowne, VA 20176

BlueRidge
SPEECH & HEARING

703-858-7620 (Voice/TDD)
703-858-7657 (fax)
www.speechhearing.org

FAMILY, SOCIAL AND EDUCATION INFORMATION

Do you have, or have you ever had, any school or learning problems? Y N

If so, please describe: _____

_____

Do you have, or have you ever had, problems with memory or thinking? Y N

If yes, please describe: _____

_____

Is there a family history of the problem that has brought you to our Center? Y N

If yes, please describe: _____

_____

Do you use tobacco? Y N If YES, amount: _____

Drink alcoholic beverages? Y N If YES, amount: _____

Drink caffeinated beverages? Y N If YES, amount: _____

What are your hobbies: _____

what, if other than your hobbies, do you enjoy doing in your spare time? _____

_____

Are you involved in any community clubs/boards/committees? If YES, please list: _____

_____

Has this problem you are experiencing interfered with your daily activities? If so, please explain:

_____

_____

Is there anything else you would like us to know? _____

_____

_____

We thank you for your time, and the care with which you filled out this form.
We look forward to serving you at our Center.