ADULT CASE HISTORY FORM

Name:_____Birthplace:_____DOB_____

Date of Report_____ AGE:_____

Sex : ____ Male ____Female _____ Intersex _____Prefer not to respond

Preferred Pronouns_____

Street Address_____

City_____ State_____ Zip_____

Home phone (____)-_____ Work Phone (____)-_____

Name of Person Completing the form (if different than above) _____

Address (if different than above)_____

_____

Dear Respondent: The following questions are asked to help us understand the above person, and plan assessment and treatment activities. Please answer them as fully as possible. If you need more space, use the back of the sheet. Thank you in advance for your time and assistance

1. Marriage Status (Circle one): Single Married Widowed Divorced

2. Name of children Age of Children

_____ _____

_____ _____

_____ _____

_____ _____

3. Native Language (if other than English)_____

4. Currently living alone (Circle one) Yes or No If no, than with whom_____

5. Handedness (Circle one) Left handed Right handed Ambidextrous

6. Highest educational level _____

7. Current Occupation and Employer_____

_____

8. If not currently employed, most recent occupation and employer_____

_____

9. Why has the appointment been requested (check all that apply)

- o Adult Language
- o Swallowing
- o Foreign Accent Reduction
- o Aphasia
- o Other_____
- o Cochlear Implant
- o Voice
- o Memory

MEDICAL HISTORY (Check all that apply)

o Stroke _____ date

- ☐ Right side weakness
- ☐ Left side weakness

o Head Injury _____ date

- Aphasia
- Other Communicative Disorder
- Dementia
- Memory Impairment
- Seizure Disorder
- Clinical Depression
- Smoker
- Hearing Loss
- Vision loss
- Voice Disorder
- Other

Please explain all items _____

_____

_____

10. Have speech and language services been sought in the past? Yes or No If yes, who was the Speech Language Pathologist and how long were services provided?

_____

11. Has psychological testing been done in the past? Yes or No

If yes, who did the testing?_____

12. Name of Primary Care Physician_____

13. Name of Audiologist_____

Date of last screening or evaluation_____

13. What do you believe to be the areas of impairment? (Check all that apply)

- Verbal Communication
- Writing
- Intelligibility of speech
- Reading
- Understanding Language
- Memory
- Problem Solving
- Swallowing

14. Is there a history of hearing loss? (Circle one) Yes or No

15. Is there a family history of hearing loss? (Circle one) Yes or No

16. Are hearing aids currently being worn? (Circle one) Yes or No

17. Communicates through gestures (Circle one) Yes or No

18. Is an assistive device or communication book currently utilized for communication? (Circle one) Yes or No

20. What are your perceived areas of strengths? _____

_____

_____

21. What are your perceived areas of weakness? _____

_____

22. In which situations do you find it most difficult to communicate or to be understood?

_____

_____

_____

18. In what areas would you like to improve most? _____

_____

_____

_____

_____

_____

RECORDS POLICY

All client records are confidential. No information will be released without the consent of the client or the person legally responsible for the client.

If you want results from this evaluation to be sent to other individuals or agencies, please complete a separate release form. All information is kept confidential as outlined in our privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

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