

**ADULT CASE HISTORY FORM  
CONFIDENTIAL INFORMATION**

Client Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Date \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Person providing case history information \_\_\_\_\_

Referred by \_\_\_\_\_

Family Information

Spouse/Partner's Name \_\_\_\_\_

Spouse's Occupation or Former Occupation \_\_\_\_\_

Number of Dependents/Children in the Home \_\_\_\_\_

Name	Age	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nature of the Problem

In your own words, describe your speech/language or hearing problem.

Background Information - History of the problem:

When was the problem first noticed? By whom?

What do you think caused or is causing the problem?

What have you done, if anything, to help the speech/language/hearing problem? (Give names, dates and places if you have received professional help in the past).

Developmental History

Are you aware of any difficulties you might have had when first learning to walk?

Does anyone have difficulty understanding what you say?

Are there any conditions that make the problem seem more or less severe?

Have you received any speech/language evaluations or therapy? If yes, where and when?

Is there a family history of speech/language problems?

Health History

Medical Care:

Physician \_\_\_\_\_ Address \_\_\_\_\_

Others consulted \_\_\_\_\_

\_\_\_\_\_

Medical Findings \_\_\_\_\_

\_\_\_\_\_

Has your hearing been tested? \_\_\_\_\_ By whom? \_\_\_\_\_

Results \_\_\_\_\_

Has your vision been tested? \_\_\_\_\_ By whom? \_\_\_\_\_

Results \_\_\_\_\_

Are you receiving any medication or treatment now? If so, please describe \_\_\_\_\_

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Illnesses and health problems (check those which apply)

\_\_\_\_\_ Asthma

\_\_\_\_\_ Frequent colds

\_\_\_\_\_ Bronchitis

\_\_\_\_\_ Frequent headaches

\_\_\_\_\_ Pneumonia

\_\_\_\_\_ Ear infections

\_\_\_\_\_ High fevers

\_\_\_\_\_ Other infections

\_\_\_\_\_ Allergies

\_\_\_\_\_ Seizures

\_\_\_\_\_ Hypertension

\_\_\_\_\_ Other (please describe) \_\_\_\_\_

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Have you had any serious injuries or accidents? \_\_\_\_\_

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Other surgery? \_\_\_\_\_

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Do you wear dentures? \_\_\_\_\_

Social and Emotional Information

Describe any other problems you are having now \_\_\_\_\_

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List your interests/leisure activities \_\_\_\_\_

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Additional Questions

Is there any other information you would like us to know?