Adult Case History Form

Speech/Language/Voice

Patient's Name: _____ Birthdate: __/__/____

Doctor's Name: _____ Doctor's Phone: _____

Referral Source (if different than regular doctor): _____

Name of person completing this form (if other than patient): _____

Patient/caregiver's preferred phone number: _____

Present Communication Status

1. What is the reason for today's visit? _____

_____

2. What date did the speech/language/voice problem(s) begin?

_____

3. Has the patient received treatment for this problem before? ☐ **Y** ☐ **N**

If yes, when and where? _____

Why was the treatment discontinued? _____

_____

4. What is the patient's primary language? _____

5. How does the patient communicate? (for example, gestures, single words, short phrases, sentences?)

_____

_____

6. Does the patient's speech/language/swallowing/voice problem interfere with job performance, social activities, or both? ☐ **Y** ☐ **N**

If yes, please describe: _____

_____

Medical History

1. Please check if the patient has ever had:

☐ Allergies ☐ Asthma ☐ Reflux disease ☐ Head Injury ☐ Stroke

☐ Cancer ☐ High blood pressure ☐ Seizures ☐ Neurological problems

Please explain any box checked above: _____

_____

2. Please describe any injury/surgery/hospitalization/ongoing medical conditions pertinent to today's visit: _____

_____

_____

3. Please list all medications: _____

_____

4. Please list any allergies: _____

_____ _____

OTHER CONCERNS

1. Does the patient have feeding or swallowing difficulties? ☐ **Y** ☐ **N**

If yes, please complete the swallowing history form.

2. Does the patient have voice concerns? ☐ **Y** ☐ **N**

If yes, please describe: _____

_____

When did the voice problems begin? _____