Central Texas Speech Pathology Services, Inc.

# 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?)

_____________________________________________________________________________________

_____________________________________________________________________________________

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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: _______________________________________________________________

_______________________________________________ ___________________________________

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## 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? ____________________________________________________