***letterhead.TIFFamily Speech Center***

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**Adult Case History Form**

**General Information**

Name: Date of Birth:

Address: City & Zip:

Phone (Home): Phone (Cell):

E-mail Address:

Occupation: Business Phone:

Employer:

Referred By: Phone:

Address:

Family Physician: Phone:

Address:

Single Married Divorced Widowed

Spouse’s Name:

Children (Include names, gender, and age):

Who lives in the home?

What languages do you speak? If more than one, which one is your primary language?

What was the highest grade, diploma, or degree earned?

Describe your speech-language/swallowing problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Have you seen any other speech-language specialist for speech, language, and myofunctional (tongue thrust) therapy? Who and when? What were their conclusions or suggestions?

Does the patient still have his/her tonsils and adenoids?

Have you seen any other specialists (physicians, psychologists, neurologist, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist’s conclusions or suggestions.

Are there any other speech, language, learning, or hearing problems in your family? If yes, please describe.

Do you have any eating or swallowing difficulties? If yes, describe.

List all medications you are currently taking.

Are you having any negative reactions to these medications? If yes, describe.

Describe any major surgeries, operations, or hospitalizations (include dates).

Describe any major accidents.

Provide any additional information that might be helpful in the evaluation or remediation process.

**MEDICAL**

If the patient has had any of the following, indicate at what age and the degree of severity.

|  |  |
| --- | --- |
| **Age/Severity** | **Age/Severity** |
| Whooping Cough | Ear Aches |
| Mumps | Running Ears |
| Scarlet Fever | Chronic Colds |
| Measles | Head Injuries |
| Chicken Pox | Venereal Disease |
| Pneumonia | Asthma |
| Diphtheria | Allergies |
| Influenza | Encephalitis |
| Polio | High Fevers |
| Headaches | Typhoid |
| Sinus | Tonsillitis |
| Meningitis | Tonsillectomy |
| Rickets | Adenoidectomy |
| Rheumatic Fever | Mastoidectomy |
| Pleurisy | Thyroid |
| Tuberculosis | Heart Trouble |
| Small Pox | Enlarged Glands |
| Croup | Convulsions |

Person completing form:

Relationship to Client:

Signed: Date: