Adult Case History Form

General Information:

Name: _____ Date of Birth: _____
Address: _____ Daytime Phone: _____
_____ Cell Phone: _____
Email: _____

Employer: _____
Occupation/ Previous Occupation: _____
Retired Since: _____
Primary Care Physician Name: _____ Physician's Phone: _____
Physician's Address: _____
_____

Referred by: _____ Phone: _____

Martial Status:

□ Single □ Married □ Widowed □ Divorced
Spouses Name: _____ Spouses Phone: _____

Children: (Use the back of this page if additional space is needed)

Name **Age**

_____
_____
_____
_____

Who lives in the home: (Use the back of this page if additional space is needed)

Name **Relationship to client**

_____
_____
_____
_____

Race/ ethnic group:

□ Caucasian, Non- Hispanic □ Hispanic □ African- American
□ Native American □ Asian or Pacific Islander □ Other _____

Which language(s) do you speak? _____
Which is your dominant language? _____

What was the highest grade completed/ diploma or degree you earned? _____

Speech- Language-Hearing

Describe your speech, language and/ or swallowing problem._____

_____

_____

_____

What do you think may have caused the problem?_____

_____

_____

Has the problem changed since it was first noticed? □ Yes □ No

How has it changed? (Worsened or improved) _____

_____

_____

Have you ever had a speech evaluation/ screening? □ Yes □ No

If yes,where & when? _____

What were the results? _____

_____

_____

Have you ever had speech therapy? □ Yes □ No

If yes,where, when & how long? _____

What were you working on/ what were your goals ? _____

_____

Have you participated in any other evaluation or therapy/ seen any other specialists (physical therapy occupational therapy, audiologists, psychologists, neurologists, etc)?

□ Yes □ No

If yes, please indicate which, and describe findings/ suggestions. _____

_____

_____

_____

Medical History:

Has your child had any of the following?

□ Adenoidectomy	□ Encephalitis	□ Seizures	□ Tonsillectomy
□ Allergies	□ Athsma	□ Sinusitis	□ Tonsillitis
□ Breathing difficulties	□ Head injury	□ High fevers	□ Chicken pox
□ Sleeping difficulties	□ Mumps	□ Pneumonia	□ Meningitis
□ Scarlet fever	□ Vision problems	□ Colds	□ Flu
□ Ear infections	□ Draining ear	□ Hearing loss	□ Tinnitus
how often?_____	□ Mastoiditis	□ German measles	□ Otosclerosis
□ Croup	□ Headaches	□ Measles	□ Noise Exposure
□ Dizziness	□ High Fever	□ Mumps	

□ Other past and current medical history: _____

_____

_____

_____

Please list all medications you take: _____

_____

_____

_____

Other serious injury, hospitalizations or surgery (What type & when/ dates)? _____

_____

_____

Have you had any recent falls within the past year? □ Yes □ No
Please describe fall and any injuries sustained: _____

_____

_____

Please provide any additional information that might be helpful for your evaluation:

_____

_____

_____

Photography Release:

_____ **Yes**, I consent for photographs and/or video images to be taken of me by SpeakEasy Therapy Factory, LLC. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media). By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me. I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

_____ **No**, I decline to give consent for use of photo(s) and video(s) of my child during therapy. I understand that declining will not impact the quality of therapy services that my child receives.

Person completing form:_____ Relationship to client:_____
Signature:_____ Date:_____ Phone#:_____

Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email. Thank you!

info@speakeasytherapyfactory.com **Fax: 803-470-4709** **Phone: 803-400-6334**