Celebrations Speech Group Inc.

Speech and Language Therapy

201 Sand Creek Rd Suite G-4 Brentwood, CA 94513 * Ph 925-529-4790 * Fax 925-401-9510
www.celebrationspeechgroup.com

Adult Case History Form

Please complete the following form and bring it to your scheduled evaluation.

Name: _____ **Today's Date:**_____
Physician: _____ **Date of Birth:**_____
Address: _____ **Age:**_____
City/State/Zip:_____ **Phone number:**_____
Email:_____ **Cell/work number:**_____
Reason/Person for Referral:
_____
_____

A. Background Information:

1. **What are your current concerns regarding your speech, language, swallowing, or motor skills**
   _____
   _____
2. **What do you think caused the above difficulties?**
   _____
   _____
3. **When was the problem first noticed?**_____
4. **Has the problem changed (worsened/resolved) since it was first noticed? Describe.**_____
   _____
5. **Have you ever seen a specialist regarding these difficulties? Who and when? What were their conclusions/recommendations? If so, do you have copies or may we obtain copies of progress and/or discharge reports?**_____
   _____
   _____

B. Medical History

1. **Do you currently have any medical diagnoses? If so, what are they?**_____
   _____
2. **Have you ever had surgery or been hospitalized for any reason? If yes, please list and indicate approximate dates.**
   _____
   _____

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3. **Do you/have you suffered from any illnesses or medical conditions? If yes, please list and indicate approximate dates.**

   _____

   _____

4. **Are you currently taking any medications? Please list.**

   _____

   _____

5. **Do you have any known allergies? (medications, foods, latex, seasonal, etc.) Please list.**

   _____

6. **Has your hearing been evaluated? If so, indicate where, when, and the status of that evaluation.**

   _____

7. **Has your vision ever been evaluated? If so, indicate when, where, and the status of that evaluation.**

   _____

8. **Do you use English as a second language? If so, what is your native language?_____**
9. **Although accent is not a disorder, do you find an accent is affecting your ability to communicate?_____**

C. Family/Social History

1. **Indicate current marital status: Single___ Widowed____ Divorced___ Married___**
2. **Describe current or past ocupation/employer:_____**

   _____

3. **Highest grade, diploma, or degree earned.**

   _____

4. **List any children (names, gender, and ages)_____**

   _____

5. **List who is currently living in your home and in what setting (i.e. 2-story house, 2nd floor apt, etc.) _____**
6. **Is there any family history of speech, language, learning, hearing, medical, or mental health issues? Describe.**

   _____

7. **List hobbies/interests:**

   _____

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8. **What is the best way you learn new things? __Written instruction __Demonstration __Verbal instruction __Hands on learning __Other:_____**

D. Therapy History

1. **Have you ever received any type of therapy (speech/language, occupational, physical)? If so, indicate which type(s) and durations.**

   _____

   _____

2. **Do others find you difficult to understand? If yes, please explain.**

   _____

   _____

3. **Do you find it hard to understand others? If yes, please explain.**

   _____

   _____

4. **Do you have short-term and/or long term memory difficulties? If yes, please explain.**

   _____

5. **Do you have difficulty with word-finding (i.e. remembering the names of objects and/or people)? If yes, explain.**

   _____

6. **Do you have difficulty with reading or writing? If yes, please explain.**

   _____

7. **Has there been any changes to your voice (i.e. hoarse, breathy, loss of volume)? If yes, please explain.**

   _____

G. Swallowing Skills

1. **Please indicate (check mark) if you have difficulty with any of the following:**

__ Chewing food __ Drooling __ Moving food to the back of the mouth

__ Managing liquids __ Increased mealtimes __ Coughing

__ Holding cup/utensils __Watery eyes when eating/drinking

__ Clearing food/liquid from the mouth __ Choking

__ Other _____

2. **Are you currently on a modified food and/or liquid diet? If yes, please explain:**

   _____

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3. **Are their food/liquid textures that you avoid?**

_____

4. **Do you currently wear dentures? Indicate full or partial.**

_____

H. Activities of Daily Living

1. **Do you require assistance with any of the following?:**

__ Dressing __Toileting __Money management/Bill payments

__ Cooking __Transportation/Driving __Keeping track of appointments

__ Eating __ Showering/Personal hygiene __Moving/Walking from place to place

__Telling time __ Making phone calls __Grocery shopping

__ Housekeeping __Other _____

2. Do you have any difficulties with fine motor skills to be able to manipulate clothing fasteners, utensils, opening jars, keyboarding, etc.? If yes, please explain.

_____
_____
_____

I, Therapy Goals

1. **What are your current speech/language related and/or occupational therapy goals/expectations?**

_____
_____

2. **Are there any issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy?**

_____
_____

***** Please provide any additional information that may be helpful to the evaluation/treatment process:**

_____
_____
_____

Completed by _____ on _____ (date)