LEBSACK SPEECH THERAPY

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:**
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/therapist 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. _____

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 an 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 ___
Spouse's Name if applicable: _____

2. Describe current or past occupation/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: _____

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. If applicable, please list conditions treated in therapy. _____
_____
_____

E. Speech and Language Skills:

1. Do you have difficulty expressing your wants and needs? If yes, please explain. _____
_____
_____

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 meal times	___Watery eyes when eating/drinking
___ Coughing	___Holding cup/utensils	___Clearing food/ liquid from the mouth
___ Choking	___ Other _____	

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

_____

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. Do you wish to proceed with private speech therapy and/or occupational therapy if needed?_____

_____

_____

3. If yes to #2, what are your preferred/available times for therapy? _____

_____

_____

_____

4. 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).

THANK YOU!