ADULT CASE HISTORY FORM

Any client applying for services at the Ludden Speech and Language Clinic is required to receive a speech and language evaluation at this facility prior to scheduling. In order to prepare and conduct the most meaningful evaluation, we would like you to provide additional information. Please answer all questions as completely and accurately as possible.

If you have any reports from other professionals (evaluations, medical records, etc.), please provide copies of those documents along with this case history form. If you have any questions, please feel free to contact us.

**Please note this is not a peanut-free facility.

The Ludden Speech and Language Clinic maintains confidentiality of all client records, including any documentation which you provide from other facilities.

GENERAL INFORMATION: (Print Clearly)

Client's Legal Name: _____ Date: _____

Client's Preferred Name (if different): _____

Date of Birth: _____ Age: _____

Address:

_____

(Street) City/State Zip Code

Home Phone: _____ Cell Phone: _____

Other: _____ Email: _____

Check all that apply:

____currently employed ____part time ____full time ____retired ____disabled

____student

Current Occupation: _____

Previous Occupation: _____

Employer/School: _____

Address of Employer/School:

_____

(Street) City/State Zip Code

Phone of Employer/School: _____

Emergency Contact:

_____

(Name) (Relationship)

Address of Emergency Contact:

_____

(Street) City/State Zip Code

Phone Numbers of Emergency Contact:

Home Phone: _____ Cell Phone: _____

Work: _____ Other: _____

REFERRAL INFORMATION & DESCRIPTION OF THE PROBLEM

Who referred you to this clinic? (List name):

_____

Profession of Person or Relationship to You:

_____

Reason for Referral:

Description of Speaking Difficulty:

Description of Listening Difficulty:

Description of Reading Difficulty:

Description of Writing Difficulty:

Description of Difficulty with Cognition (e.g., memory, attention, problem-solving, etc.):

When did your communication problem first begin?

_____

Has the problem ___ remained the same ____ gradually worsened ____ worsened quickly?

How severe is your communication difficulty?
___minimally impaired ___mildly impaired ___moderately impaired ___severe ___very severe

What are your goals for your communication? What would you like to be able to do better?

EDUCATIONAL HISTORY

Name of Last School Attended:

_____

Number of Years You Attended School: _____Highest Degree Earned: _____

FAMILY HISTORY

Your current marital status: ____married ____single ___widowed ____other

Number of children you have: _____ What are their ages? _____

List the Names of Those Living with You	Relationship to You (spouse, child, friend, etc.)
Name: _____	_____
Name: _____	_____
Name: _____	_____
Name: _____	_____
Name: _____	_____
Name: _____	_____
Name: _____	_____

Is English your native language: _____Yes _____No (list language) _____

What language(s) are spoken in your home? _____

Do you have a developmental disability, syndrome or learning disability? _____No _____ Yes (Describe)

Does anyone in your family have a developmental disability, syndrome, learning disability, or history of speech, language or hearing difficulties? _____No _____Yes (describe)

MEDICAL HISTORY

General Health: _____Excellent _____Good _____Fair _____Poor

What medical diagnosis is associated with your communication difficulty?

_____ Date of onset_____

Past & Current Medical History
Please check the "Yes" or "No" box to indicate whether you have/had any of the following:

Yes	No		Yes	No	
[ ]	[ ]	Diabetes	[ ]	[ ]	Frequent Colds
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Laryngitis/hoarseness
[ ]	[ ]	Thyroid Problems	[ ]	[ ]	Dental Problems
[ ]	[ ]	Heart Attack	[ ]	[ ]	Attention Deficit Disorder
[ ]	[ ]	Other Heart Disease	[ ]	[ ]	Mental Illness
[ ]	[ ]	Respiratory Problems	[ ]	[ ]	Schizophrenia
		(asthma, emphysema, other)	[ ]	[ ]	Bipolar
[ ]	[ ]	Gastrointestinal	[ ]	[ ]	Depression
		(digestive problems)	[ ]	[ ]	Fatigue
[ ]	[ ]	Reflux (GERD)	[ ]	[ ]	Stress
[ ]	[ ]	Allergies	[ ]	[ ]	Anxiety Disorder
[ ]	[ ]	Kidney Problems	[ ]	[ ]	Obsessive Compulsive
[ ]	[ ]	Arthritis	[ ]	[ ]	Asperger's/Social Language
[ ]	[ ]	Lupus	[ ]	[ ]	Congenital Disorder (List):
[ ]	[ ]	Stroke	[ ]	[ ]	Dyslexia
[ ]	[ ]	Traumatic Brain Injury (including concussion)	[ ]	[ ]	Viruses (HIV, Herpes, Hepatitis)
[ ]	[ ]	Epilepsy/Seizures	[ ]	[ ]	Stuttering
[ ]	[ ]	Parkinson's Disease	[ ]	[ ]	Hearing Problems
[ ]	[ ]	Tremors	[ ]	[ ]	Surgeries
[ ]	[ ]	Headaches			(list) _____
[ ]	[ ]	Meningitis	[ ]	[ ]	Other Medical Diagnoses
[ ]	[ ]	Other Neurological Disorders			(list) _____
[ ]	[ ]	Bleeding Disorders			(list) _____
[ ]	[ ]	Cancer (List part of the body affected):_____			
[ ]	[ ]	Swallowing Difficulty (if yes, please describe the difficulty that you have/had swallowing)			

If you answered yes to any of the above, please explain and comment below.

Describe any special techniques, equipment, and compensations you use.

Do you eat a special diet? _____Yes _____No
If yes, list the type of special diet, including altered consistencies (soft, pureed, thickened liquids)

Are you sensitive to latex? _____Yes _____No

List all medications taken on a regular basis:

List all previous hospitalizations, reason and dates (add a piece of paper if needed)

Have you ever been seen by any of the following specialists? Check all that apply:

_____ Neurologist _____ Behavior Specialist _____ Orthodontist

_____ Psychiatrist _____ Physical Therapist _____ Dietitian

_____ Audiologist _____ Occupational Therapist _____Psychologist

_____Ear Nose Throat Physician _____ Other _____

Are you under the care of a doctor or medical specialist now? If so, list name and reason:

Please list names/approximate dates/and reasons for all specialists you have seen in the past (add a piece of paper if needed)

COMMUNICATION HISTORY AND CURRENT STATUS

Please check all statements that apply to your communication disorder and elaborate:

_____ My communication problem interferes with my social activities.

_____ My communication problem interferes with my performance at work.

_____ My communication problem interferes with my performance at school.

_____ My communication problem interferes with my home life.

_____ I am able to express myself so other can understand me.

_____ At times, my speech improves, but it gets worse again.

_____ I have difficulty recalling the names of common objects, people or places.

_____ My communication is not easily understood by people I know.

_____ My communication is not easily understood by strangers.

_____ I frequently say the wrong sounds in words.

_____ I am concerned about how well people understand my speech.

_____ My speech contains many word repetitions or prolonged sounds.

_____ I often run out of breath while talking.

_____ It takes a great amount of effort to talk.

_____ I have difficulty reading.

_____ I have difficulty learning and remembering new information.

_____ I have difficulty remembering things that I need to do, such as appointments or tasks for work.

_____ I have difficulty paying attention while having a conversation or completing a task.

.

_____ I have difficulty thinking through problems to find solutions.

Have you ever been seen by a Speech/Language Pathologist (SLP)? _____Yes _____No
If yes, please provide reports.

Do you have a hearing loss? _____ No _____ Yes

Do you wear a hearing aid? _____ No _____ Yes

Do you have any vision problems? _____ No _____ Yes

Do you wear eyeglasses or contacts? _____ No _____ Yes

What are your interests and activities that you enjoy?

Overall, I would rate my communication as:

_____ Excellent _____ Good _____ Fair _____ Poor

Do you have any other comments that may be helpful to us in planning your evaluation?

Please include any additional reports or information that might be helpful in the evaluation and/or remediation of your child's speech/language problem.

Person Completing Form: _____

Relationship to Client: _____

Signature of Legal Guardian (if applicable)_____Date:_____

Signature of Client_____ Date: _____

Form Updated 11-5-2017