Jacksonville Speech & Hearing Center

Communication Matters

SPEECH-LANGUAGE PATHOLOGY
Adult Case History Form

CONFIDENTIAL REPORT: All of the following information is for the use of the Center's Professional Staff and will be handled in confidence.

A request has been made for examination of your Speech/ Language and/or Cognitive skills. In preparation for the examination, we would like you to provide, as best you can, the requested information on this form. This information will assist the SHC, Inc. staff in completing a meaningful examination.

Please answer the following questions fully and as accurately as possible. If you are not sure of a particular date, please write the date that you think is correct and place a question mark next to it.

DATE _____ PERSON COMPLETING FORM _____

RELATIONSHIP TO PATIENT _____

PATIENT _____ BIRTHDATE _____ SEX __
Last First Middle

ADDRESS _____ TELEPHONE _____

City _____ State _____ County _____ Zip _____

PHYSICIAN _____ ADDRESS _____

Who referred you to this center? _____

Have you been treated at this center before? **Y/N** If yes, when? _____

Briefly describe the problem for which you wish to be seen: _____

_____

_____

_____

When was the problem first noticed? _____

Have you received any other therapy for this problem? **Y/N** If yes, when and where? _____

_____

Any record of speech and/or hearing problems in your father's or mother's family? **YES** **NO**

Any emotional problems in your father's or mother's family? **YES** **NO**

Any learning problems in your father's or mother's family? **YES** **NO**

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HEALTH HISTORY

Health of your mother during the pregnancy resulting in your birth
Excellent **Good** **Fair** **Poor**

Your approximate birth weight? _____ lbs. _____ oz.

Have you experienced any major illnesses? **Y/N** If yes, please describe: _____
_____

Do have any major medical diagnoses? **Y/N** If yes, please list diagnosis and date diagnosed: _____
_____
_____

Have you had any major surgeries? **Y/N** If yes, please list type and date of surgery: _____
_____
_____

Are you currently taking any medications? **Y/N** If yes, please list medication and dose: _____
_____

Please list any drug allergies: _____

Please circle:

Physical development as a child was:	fast	normal	slow	
Physical coordination now is:	good	clumsy	other	
Eye problems	yes	no		
History of high fevers	yes	no		
History of seizures or convulsions	yes	no		
Any serious accidents	yes	no		
Any dizziness or loss of balance	yes	no		
Have tonsils and adenoids been removed	yes	no		
Do you have frequent colds/sore throats/earaches	yes	no		
Have you ever lost consciousness	yes	no		
Have you ever worn a hearing aid	yes	no		
Present physical status	excellent	good	fair	poor

Any other medical or behavioral problem not listed above, please describe here: _____
_____

EDUCATIONAL/EMPLOYMENT/FAMILY HISTORY

Education level completed: _____ Year: _____
Occupation: _____ Are you currently working? **Y/N**
Hobbies: _____
Marital Status: _____ Single _____ Married _____ Divorced _____ Separated
_____ Widowed

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Other family members in household:

Name	Relationship	Age	Education/Occupation
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Is there a particular person who is a major source of assistance for you? **Y/N** Who? _____

ADDITIONAL COMMENTS/OTHER IMPORTANT INFORMATION

Is there any other information you feel would help us in our evaluation? _____
_____
_____

Are there any particular questions you would like to ask us? _____
_____
_____

Have you thought about or made an application to any other agencies for evaluation and therapy? **Y/N**
When? _____ Where? _____

The Speech & Hearing Center, Inc. is a private, not-for-profit corporation. Fees constitute the majority of our operating budget. Your cooperation in payment of fees in full at the time of service is required, unless other arrangements have been made prior to the date of service.

Thank you for your time and attention in completing this history form!!

Signature of Person Completing this form: _____
Relationship to Patient: _____

*** **Please sign and date the enclosed Medical Records Release form.** THANK YOU!!

***** **Copies of Medical Records related to the problem for which you wish to be seen must be attached and sent with this Case History Form.....**
A Medical History, related to the condition to be treated, is pertinent to clinician preparation and planning of evaluation, therapy goals, and on-going treatment. *****

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