Adult Communication Case History Form

Please complete and bring to your first appointment or send to our office prior to your evaluation.

Patient's Name:

Patient's Date of Birth:

Name of person completing this form:

Relationship to the patient:

Date form completed:

Briefly describe your concerns regarding speech and language or swallowing:

When and how did the difficulty begin?

Did the problem begin suddenly or gradually?

What is the number one thing you hope to get from today's assessment?

Medical History

Please list any medical conditions you have:

List any surgeries:

Please list all current medications or bring a copy of your medications with you:

Please list any allergies:

Have you been hospitalized in the past 12 months?	Yes	No
If yes, please explain:		
Are you a current or former smoker?	Yes	No
Do you have any vision difficulty?	Yes	No
Do you have any hearing difficulty?	Yes	No
Do you have any difficulty with mobility or numbness?	Yes	No
Have you been seen by speech therapy in the past?	Yes	No
Do you receive any other types of therapy?	Yes	No
Have you had any imaging done? (i.e. CT, MRI, ultrasound, swallow study, scope, etc.)	Yes	No
If yes, what were the findings?		

Social History

Please describe your living situation. (home alone, home with family, with aide)
What is your highest level of education?
What is, or was, your occupation?
What languages do you speak?
What are your hobbies or interests?

Symptoms

Others find you difficult to understand	Yes	No	**Do you require assistance with:**		
You find it hard to understand others	Yes	No	Dressing	Yes	No
Trouble getting words out	Yes	No	Toileting	Yes	No
Short term memory trouble	Yes	No	Money Management/ Bill Payments	Yes	No
Long term memory difficulty	Yes	No	Cooking	Yes	No
Trouble maintaining topic of conversation	Yes	No	Transportation/ Driving	Yes	No
Trouble with reading or writing	Yes	No	Keeping track of appointments	Yes	No
Difficulty focusing or paying attention	Yes	No	Eating	Yes	No
Changes to your voice (i.e. hoarse, breathy, loss of volume)	Yes	No	Showering/ Personal Hygiene	Yes	No
Trouble speaking fluently	Yes	No	Walking	Yes	No
Difficulty swallowing	Yes	No	Telling Time	Yes	No
Problems chewing food	Yes	No	Making phone calls	Yes	No
Coughing or choking during or after meals	Yes	No	Grocery Shopping	Yes	No
Food gets stuck in your throat	Yes	No	Housekeeping	Yes	No
Trouble swallowing pills	Yes	No	Other	Yes	No