ADULT CASE HISTORY FORM

Name of person completing form:

Relationship to client:

General Information

Name: _____

Gender: _____

Preferred name/pronouns: _____

DOB: _____

Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Contact Phone Number: _____

Email Address: _____

Emergency Contact: _____ Telephone Number: _____

Relationship: _____

Are you affiliated with Salus University?

Yes ___ ID # _____

No ___

Occupation:

Employer:

Referred by: _____

Primary Concern:

Reason for requesting an evaluation: _____

Difficulty with (check all that apply):

Voice __

Speech __
Swallowing/eating __
Cognition/Thinking skills __
Communication/Language skills__

Please provide any additional information that might be helpful in our evaluation or treatment planning. _____

Are there any medical diagnoses related to your primary concern/reason for seeking speech therapy?

If recently hospitalized, please give location and dates of hospitalization:
Hospital, Location, Date Admitted-Discharged

Do you use an assistive device for mobility (e.g. wheelchair, cane, power scooter)?

No: ___

Yes: What assistive device(s) do you use _____

_____

***Ethnicity:** Hispanic or Latino, Not Hispanic or Latino, Other/Declined to specify

***Race:** _____

0 = Not reported/Declined to Specify **1**= American Indian/Alaska Native

2 =Black/African American **3** = Asian/ Pacific Islander **4** = White/Caucasian

* This information is requested solely for the purpose of describing caseload diversity. Your response will not affect consideration of your application.