SALUS UNIVERSITY
Speech-Language Institute

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ADULT CASE HISTORY FORM

Please answer the following questions as best you can and mail the form to the address at the top of this page. If there are some questions you cannot answer, leave them blank. Your answers will help us provide you with the best and most efficient evaluation and/or treatment.

General Information

Name ______________________________________ DOB: __________________Age ________

Address: ____Gender ____________

City _______________________________________ State _______Zip _____________________

Home Phone ________________ Business Phone _____________Cell Phone _______________

Email Address_________________________ May we contact you at work? Yes No

Are you affiliated with Salus University? Yes ID # ____________________ No

Occupation ___________________________ Employer ________________________________

Name of person completing form ____

Relationship ____

Referred by ____

Marital Status _______________________________ Spouse's name _______________________

Who lives in the home? ____

Race of the client*____

0 = Not reported 1= American Indian/Alaska Native 2 = Black/African American 3 = Asian/ Pacific Islander 4 = Hispanic 5 = White/ Caucasian

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

Health Insurance: ____

Name of Policy Holder: ____

Policy Number: ____

Educational History

Highest level of education achieved ___________________ Primary Language ______________

Other languages spoken ___________________ Language spoken in the home ______________

Do you have any reading and/or learning difficulties? Yes No

If yes, please describe ____
____
____

Present Speech, Language or Voice History

As completely as possible, describe your speech and or language problem. __________________
____
____

How long have you had this problem? ____
____

What do you think caused this problem? ____
____
____

How has the problem changed since it was first noticed? _____________________________
____

How does this problem affect you? ____

In your family? ____

Socially? ____

Vocationally? ____

Have you sought help for this problem elsewhere? Yes No

Please list the names of other clinics or agencies where you have been seen for evaluation or treatment of your communication problem.

Name Location Dates

1. ____
2. ____
3. ____
4. ____

Medical History

Is there a medical reason for your present communication problem? Yes No

When did it occur? ____________________ Describe ______________________________
____
____
____

If hospitalized, please give location and dates of hospitalization.

Hospital/ Location/ Date Admitted-Discharged/ Name of Physician treating this medical problem
____
____
____
____

List diseases/conditions and the date of onset:______ ______________________________
____
____
____

List significant injuries/accidents and any effects: ______________________________
____
____
____

Any other medical/treatment information: ____________________________________
____
____

Do you have any eating or swallowing problems? Yes No
Describe ____

____

Please list any medication that you are currently taking (name/dosage/schedule) ________

____

____

____

____

____

F. Does you have any allergies or dietary restrictions? ______________________

____

____

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

____

____

Primary Care Physician Name ____

Location ____

Phone ____

Specialist ____

Location ____

Phone ____