



4710 OLD TROY PIKE • DAYTON, OHIO 45424
PHONE: (937) 233-1230
TDD: (937) 236-8936
FAX: (937) 236-8930

ADULT SPEECH THERAPY CASE HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Name / Relationship of person completing this form: _____

Patient's primary physician: _____

Please describe the problem(s) for which you seek speech therapy: _____

When did the problem(s) begin (date)? _____

Has this patient ever had the problem(s) before? (circle) Yes No If yes, please describe: _____

Has this patient ever received speech therapy or any other treatment for this condition?
Yes No If yes, what type and where? _____

What languages are spoken in the home? _____

What is the patient's primary language? _____

How does the patient communicate? (for example, gestures, single words, short phrases, sentences?) _____

Has the problem changed since it was first noticed? _____

Please check if this patient has ever had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colds |
| <input type="checkbox"/> Reflex disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung disease |

Please explain any box checked above: _____

Has this patient ever had surgery? (circle) Yes No If yes, please describe and include dates: _____

List any medications that this patient presently taking (prescription and non-prescription):

List any allergies: _____

Have you had any testing done recently (for example, x-rays, MRI, blood tests, etc)?

Yes No If yes, what were the results? _____

Have there been any hospitalizations? Yes No If yes, please describe and include dates: _____

How does this patient learn best? (circle)

Reading Listening Demonstration Other _____

Does this patient have any customs or religious beliefs or wishes that might affect his/her care? _____

Swallowing History

(Please disregard this section if your appointment is for a Speech and Language Evaluation only)

Please describe in detail the nature of the swallowing problem: _____

When did the swallowing problem start? _____

Has the swallowing problem gotten better or worse? (circle) Yes No

If yes, please describe: _____

Does the swallowing problem happen with certain foods or liquids? Please describe: _____

Does the swallowing problem happen at different times of the day? _____

Have you had a video swallowing study in the past? If so, when? What were the results?
