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.

Name of person completing form: ____

Relationship to client: ____

General Information

Name: ________________________________ **DOB:** ______________ **Age:** ________

Address: ____ **Gender:** ________

City: ____________________________ **State:** ___________ **Zip:** __________________

Preferred Contact Phone Number: _________________________

Email Address: ____

Are you affiliated with Salus University? **Yes ID #** _________________ **No**

Occupation: _______________________ **Employer:** ______________________________

Referred by: ____

Marital Status: ___________________________ **Spouse's name:** ___________________

Who lives in the home? ____

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

___ Yes: What assistive device(s) do you use ______________________________?

___ No

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.

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 ____

____

____

Speech & Language History

Please check any of the following characteristics that are true for you now:

Language:

- ___ difficulty thinking of words (names of people, objects etc)
- ___ difficulty speaking in complete sentences
- ___ difficulty understanding directions or questions
- ___ difficulty following along in conversation
- ___ difficulty reading and/or writing (briefly describe in space below)

Swallowing:

- ___ difficulty swallowing foods or liquids
- ___ coughing/choking during meals
- ___ drooling
- ___ pain when swallowing

Speech:

- ___ difficulty coordinating voice, tongue, lips to produce speech
- ___ mispronounce words (omit a sound or substitute sounds while speaking)
- ___ pronounced foreign or regional accent that interferes with communication
- ___ stuttering or stammering while talking
- ___ feel overly tense while talking
- ___ repeat sounds, words, parts of words or phrases when speaking
- ___ difficulty, or need to pause, before saying certain words or sounds

Voice:

___ loss of breath during speech

___ hoarse or rough voice when speaking

___ pain in throat while speaking

___ voice sounds like it is coming through the nose (nasal)

___ voice sounds like I have a cold

___ listeners complain that I always talk too softly or too loudly

___ voice is abnormally low-pitched or high pitched

___ voice is worse at certain times of the day or during certain seasons

Thinking Skills:

___ difficulty remembering events or appointments

___ difficulty solving daily problems

___ difficulty organizing complex events (e.g. trip planning, holiday dinners, etc.)

___ difficulty paying attention for an extended period or when distractions are present

___ other (please describe)

____

____

How does this problem affect you? ____

In your family? ____

Socially? ____

Vocationally? ____

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. ____

<u>Medical History</u>
Please check any medical conditions:

___ **Allergies (seasonal)**

___ **Falls frequently/balance issues**

___ **Amputations**

___ **Hearing:**

- ___ Cochlear Implant
- ___ Ear Infections
- ___ Hearing aids (left/right)
- ___ Hearing Amplification (other) __________________
- ___ Meniere's Disease
- ___ Noise Exposure
- ___ Tinnitus

___ **Attention Deficit Disorder (ADD)**

___ **Attention Deficit/Hyperactivity Disorder (ADHD)**

___ **Neuromuscular Disease**

- ___ Amyotrophic Lateral Sclerosis (ALS)
- ___ Epilepsy
- ___ Multiple Sclerosis (MS)
- ___ Muscular Dystrophy (MD)
- ___ Parkinson's disease (PD)
- ___ Other: _____________________

___ **Autism**

___ **Cancer**: type____________________

___ **Sensory Integration Disorder**

___ **Cerebral palsy**

___ **Brain Disorder:**

- ___ Alzheimer's Disease
- ___ Dementia
- ___ Encephalitis/Meningitis
- ___ Seizure Disorder/Seizures
- ___ Other: __________________

___ **Psychological**

- ___ Anxiety
- ___ Depression
- ___ Other: ____________________

___ **Respiratory (Lungs)**

- ___ Asthma
- ___ COPD
- ___ COVID/lasting effects of COVID
- ___ Lung Disease
- ___ Pneumonia (date) ___________
- ___ Other: ____________________

___ **Cardiac (Heart):**

- ___ Atrial Fibrillation/Arrhythmias
- ___ Congenital Heart Disease
- ___ Coronary Heart Disease
- ___ Heart Attack (date) ________
- ___ High Blood Pressure
- ___ Other: ___________________

___ **Physical Abnormalities**

___ **Serious injury** ___________________

___ **Coma**

___ **Surgery:** _______________________

___ **Cerebrovascular Accident (CVA)/Stroke**

___ **Syndrome (other):**

____

___ **Dental:**

- ___ Braces
- ___ Dentures (upper/lower)
- ___ Cleft Palate
- ___ Other: ____________

___ **Diabetes**

___ **Digestive problems**

___ **Dyslexia**

___ **Traumatic Brain Injury (TBI)**

- ___ Auto accident
- ___ Concussion (date)
- ___ Post Concussive Syndrome
- ___ Other: __________________

___ **Vocal fold pathologies (Voice)**

- ___ Intubation: length of time:
- ___ Hoarseness
- ___ Laryngectomy
- ___ Polyps/ Nodules
- ___ Speaking valve

___ **Other:**

____

____

____

If hospitalized, please give location and dates of hospitalization.

Hospital, Location, Date Admitted-Discharged

____

____

____

____

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

____

____

____

____

____

____

Do 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 ____

Specialist ____

Location ____

Phone ____

Specialist ____

Location ____

Phone ____

Specialist ____

Location ____

Phone ____