



Communication Sciences and Disorders
College of Education
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FLORIDA ATLANTIC UNIVERSITY - COMMUNICATION DISORDERS CLINIC
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SPEECH AND LANGUAGE CASE HISTORY - ADULT FORM
(CVA, TBI, other neuropathologies)

GENERAL INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_M/ \_\_\_F

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

Name of Spouse/Guardian: \_\_\_\_\_

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Person to contact in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell/Mobile: \_\_\_\_\_

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NATURE OF THE PROBLEM

Describe speech/language problems \_\_\_\_\_

Cause of speech/language problem (accident, stroke, illness)

Date of the injury (accident, stroke, illness) \_\_\_\_\_

**MEDICAL HISTORY**

Were you unconscious? \_\_\_\_ paralyzed? \_\_\_\_ did you have convulsions? \_\_\_\_

If yes, describe \_\_\_\_\_  
\_\_\_\_\_

Following the injury or incident, how soon were you seen by a physician?

\_\_\_\_\_

Were you hospitalized? \_\_\_\_\_

If yes, how long? \_\_\_\_\_

Name of Hospital \_\_\_\_\_

Address \_\_\_\_\_

If not hospitalized, describe your care

\_\_\_\_\_  
\_\_\_\_\_

Are you now under a physician's care? \_\_\_\_\_

If yes, for what reason? \_\_\_\_\_

\_\_\_\_\_

What medication(s) are you now taking?

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Your health before this accident or illness was excellent? \_\_\_\_\_  
average? \_\_\_\_\_ fair? \_\_\_\_\_ poor? \_\_\_\_\_

Prior to this accident or illness, have you ever had a heart condition? \_\_\_\_\_  
high blood pressure? \_\_\_\_\_ previous strokes? \_\_\_\_\_ seizures? \_\_\_\_\_  
fainting spells? \_\_\_\_\_

Other operations/illnesses/accidents

Problem	Date
_____	_____
_____	_____
_____	_____
_____	_____

Do you wear glasses? yes \_\_\_\_\_ no \_\_\_\_\_

Describe vision problem \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIANS**

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**IMMEDIATE FAMILY**

Mother's name \_\_\_\_\_ living \_\_\_ deceased \_\_\_

Father's name \_\_\_\_\_ living \_\_\_ deceased \_\_\_

Brother(s) Name	State	Age
_____	_____	_____
_____	_____	_____

Sister(s) Name	State	Age
_____	_____	_____
_____	_____	_____

Children: Name	State	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Grandchildren: Name	State	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is client living at home? \_\_\_\_\_ yes \_\_\_\_\_ no

If no, where does client live? \_\_\_\_\_

If yes, who lives at home with the client?

Name	Relationship
_____	_____
_____	_____

Does client require complete care? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, who provides this care? \_\_\_\_\_

To what extent can the patient care for him/herself?

Dress \_\_\_\_\_

Feed \_\_\_\_\_ Wash \_\_\_\_\_

What is the client's native language? \_\_\_\_\_

If other than English, when did the client learn English? \_\_\_\_\_

### EDUCATIONAL/WORK HISTORY

School	Location	Degree
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is/was the client's occupation? \_\_\_\_\_

Is the client presently working? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, where and what hours? \_\_\_\_\_

### SPEECH AND LANGUAGE

Describe the client's ability to communicate. \_\_\_\_\_

Does the client have a hearing loss? \_\_\_\_\_ yes \_\_\_\_\_ no

Does the client use a hearing aid? \_\_\_\_\_ yes \_\_\_\_\_ no

Have you read/heard anything about the client's disorder? \_\_\_\_\_

If so, what?

How have the client's social activities changed, if at all?

What are the client's interests or favorite activities?

	yes	no
Is the client attempting to communicate verbally?	_____	_____
Does the client give his/her name and address?	_____	_____
Is the client's speech understood by family and friends?	_____	_____

Does the client use sentences to communicate? \_\_\_\_\_|\_\_\_\_\_

Does the client use phrases to communicate? \_\_\_\_\_|\_\_\_\_\_

Does the client repeat words? \_\_\_\_\_|\_\_\_\_\_

Is there automatic speech e.g. counting, days of the week, profanity, etc.? \_\_\_\_\_|\_\_\_\_\_

Does the client appear to understand what is said to him/her? \_\_\_\_\_|\_\_\_\_\_

Does the client read? \_\_\_\_\_|\_\_\_\_\_

Does the client appear to understand what he/she reads? \_\_\_\_\_|\_\_\_\_\_

Does the client watch and understand TV ? \_\_\_\_\_|\_\_\_\_\_

Below are words which describe a person's personality and behavior. Circle the words which you feel apply to the client's present status.

happy	very friendly	moody	jealous	responsive		
indifferent	troubled	tense		argumentative	shy	
critical	listless	bossy		distractible	even tempered	independent
tires easily	relaxed	resistant		outgoing	energetic	impatient
active	can't sleep	patient		hostile		
sad	motivated					
has temper tantrums		exhibits control of emotions				
focuses on tasks		seeks social relationships				
prefers to be alone		demands attention				
willing to try new things		tunes out people				

Has the client been seen for:

	<b>Dates</b>	<b>Agency/Address</b>
speech/language therapy	_____	_____
	_____	_____
physical therapy	_____	_____
	_____	_____
occupational therapy	_____	_____
	_____	_____
psychological counselling	_____	_____
	_____	_____
other rehabilitation	_____	_____
	_____	_____

\_\_\_\_\_  
Name/relationship of person completing form

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date