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

GENERAL INFORMATION Date:________________

Name:____

Date of Birth:_____________ Sex: ____M/ ____F

Address:____

____

Home phone: _______________ Work: _________________ Cell: ____________________

E-mail: ____

Name of Spouse/Guardian:____

****

Person to contact in case of emergency:

Name:________________________________ Relationship:___________________

Home phone:_____________ Work: ______________ Other: ________________

****

Speech-Language Problem: ____

MEDICAL HISTORY

Your health is excellent?_____ average?_____ fair?_____ poor?_____

Have you ever been hospitalized? __________

If yes, for what and for how long?____

____

____

Are you now under a physician's care?___________

If yes, for what reason?____

____

What medication(s) are you now taking?

Name	Dosage
____	__________________________
____	__________________________
____	__________________________
____	__________________________

Operations/illnesses/accidents/

Problem	Date
____	__________________________
____	__________________________
____	__________________________
____	__________________________

Do you wear glasses? yes______ no______
Describe vision problem:____

____

PHYSICIAN(S):

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
____________________	________________________________	________
____________________	________________________________	________
____________________	________________________________	________
____________________	________________________________	________
____________________	________________________________	________

What is the client's native language? ___________________________

If other than English, when did the client learn English? ______________________

____

EDUCATIONAL/WORK HISTORY

School	Location	Degree	Date
_________________	_________________________	___________	________
_________________	_________________________	___________	________
_________________	_________________________	___________	________

What is/was the client's occupation? ______________________________________
Is the client presently working? _______ yes _______ no

If yes, where and what hours? ____

SPEECH AND LANGUAGE

Describe speech/language problem(s):______________________________________

____

____

Cause of speech/language problem(s) (if known)

____

____

When did problem first become noticeable?_______________________________

____

Are there any family members with speech, language, and/or hearing problems?
___yes ____no

If yes, describe:____

____

Does the client have a hearing loss? _______ yes _______ no
Does the client use a hearing aid? _______ yes _______ no

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

____

____

What are the client's interests or favorite activities?

____

____

Has the client been seen for:

	Dates	**Agency/Address**
speech/language therapy	____________	____________________________________
		____________________________________
physical therapy	____________	____________________________________
		____________________________________
occupational therapy	____________	____________________________________
		____________________________________
psychological counselling	____________	____________________________________
		____________________________________
other rehabilitation	____________	____________________________________
		____________________________________

Additional Comments/Information:

____
Name/relationship of person completing form

____ _____________
Signature Date