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Speech-Language Hearing Center
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SOCIAL-MEDICAL-DEVELOPMENTAL CASE HISTORY
ADULT FORM (16 years and over)

Instructions: Please complete the following information to the best of your ability and as completely as possible. The information contained in this form will be used by our diagnostic team to develop a plan and generate a report. If you need more space, please feel free to use the back of the form.

General Demographic Information:

Date:			
Client's Name		Client's Preferred Name	
Client's Gender	□ Male □ Female	Client's DOB	
Client's Race	□ Caucasian □ African American □ Indigenous □ Hispanic □ Other_____		
Person Completing Form:		Relationship to client:	
Primary Language	Client in the home: □ English □ Spanish □ Other_____ Client in the community: □ English □ Spanish □ Other_____	Parent/Caregiver in the home: □ English □ Spanish □ Other_____ Parent/Caregiver in the community: □ English □ Spanish □ Other_____	
Address:	Address 1:		
	Address 2:		
Phone Number(s):	Primary Contact Number:		
	□ Work □ Home □ Cell □ Other_____		
	Secondary Contact Number:		
	□ Work □ Home □ Cell □ Other_____		
Please complete the guardian section if client is 18 years of age or under			
Mother's Name		Father's Name	
Mother's Occupation		Father's Occupation	
Mother's Email		Father's Email	
Primary Guardian Name (if different from parents)		Referred by:	
Individuals living in the home and age	Client primarily lives: □ With Spouse □ With Partner □ Independently/Roommate □ With both parents □ With mother □ With father □ With guardian □ With Grandparents □ With Foster Parent/Guardian Name:_____ Age:_____ Name:_____ Age:_____ Name:_____ Age:_____ Name:_____ Age:_____		
Name and address of Primary Care Physician			

Physical-Medical History:
My health is currently: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check all items that apply. Explain all checked items.

Items	When Occurred	Change in Abilities
☐ Allergies		
☐ Asthma		
☐ Attention Deficit Disorder (ADD)		
☐ Autism Spectrum Disorder (ASD)		
☐ Anxiety		
☐ Depression		
☐ Cancer		
☐ Chronic colds		
☐ Emphysema		
☐ Head or Neck Trauma		
☐ Hearing Problem		
☐ Dental Problem		
☐ Heart Problem		
☐ Swallowing Difficulty		
☐ Hormonal Imbalance		
☐ Hypertension (high blood pressure)		
☐ Laryngitis		
☐ Psychological Disorder		
☐ Seizure Disorder		
☐ Sore Throat		
☐ Vocal Polyps or Nodules		
☐ Stroke		
☐ Tonsillectomy		
☐ Other:		

Are there any other relevant diagnoses, surgeries, or hospitalizations?	□ No □ Yes If yes, please describe what for/when:
Has the client ever been examined by a neurologist?	□ No □ Yes If yes, please describe findings:
Does the client have any known food or latex allergies?	□ No □ Yes If yes, please describe:
Is the client currently on any medication (OTC/prescribed)?	□ No □ Yes If yes, please list or bring a list with you to your appointment:
Has the client's hearing been tested?: Results of hearing test:	□ No □ Yes □ Hearing within normal limits □ Hearing loss □ Further testing required □ Use amplification
Does the client use any of the following assistive devices?	□ Wheelchair □Walker □ Cane □ Other: _____ □ None
Is the client able to climb stairs?	□ No □ Yes
What hand does the client use for writing, eating, etc.?	□ Left □Right
Vision History	Do you have concerns about the client's vision? □ No □ Yes Does the client wear glasses? □ No □ Yes Is there family history of vision problems? □ No □ Yes If yes, explain_____ When was the client's vision last assessed?_____
Is the client able to: Provide all self-care (i.e., bathing, clothing, cooking, meds). Complete their own typical daily activities? Manage their own finances?	 □ No □ Yes If no, please describe: □ No □ Yes If yes, please describe: □ No □ Yes If yes, please describe:

Social/Educational History:

Client's Marital Status	□ Single □Significant Partner □Married □Divorced □ Widowed □Other _____
Children: Names + Ages	_____ _____ _____
Highest Level of Education Completed	□ GRE □ High School □ Associate's/Technical Degree □ Bachelor's Degree □ Master's Degree □ Doctorate □Other _____
Employment (check all that apply):	□ Part time □ Full time □ Retired □ Disabled □ Student
Current Occupation:	_____
Employer:	_____

Presenting Complaints:
In your own words, describe what concerns you have about the client:

_____
_____
_____

What do you hope to gain, or questions do you hope to have answered, from this evaluation experience?

_____
_____
_____

What has been done to address the concern up to the date of this referral? (If the client has had previous speech-language or hearing evaluations or therapy, please indicate where and approximate dates.)	☐ Speech-Language Therapy _____ ☐ Occupational Therapy _____ ☐ Physical Therapy_____ ☐ Behavior/Counseling_____ ☐ Genetic/Neuro Counseling _____ ☐ Other _____
Does the client have a developmental disability, syndrome, or learning disability?	☐ No ☐ Yes If yes, please describe:
Anyone in the client's family have a developmental disability, syndrome, learning disability, or history of speech, language, or hearing difficulties?	☐ No ☐ Yes If yes, note the person's relationship to the client and what type of difficulties they had/have:

Speech-Language History (put a checkmark in the box that most applies)**:**

Symptom (I have problems with….)	**Never**	**Sometimes**	**Frequently**
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic conversation			
Non-fluent speech (stuttering)			
Following directions			
Oral motor weakness (difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			
Any other difficulties			

Description of the Problem:

Reason for referral (please check yes or no):	Reading: □ Yes □ No Writing: □ Yes □ No Speaking: □ Yes □ No Listening: □ Yes □ No Cognition: □ Yes □ No Voice: □ Yes □ No Swallowing □ Yes □ No Other: □ Yes □ No Please provide more information on any items checked "yes" above: _____ _____ _____		
When did this problem begin? (please give a specific date if possible.)	_____ _____ _____	Did the problem begin suddenly or develop over time?	☐ Suddenly ☐ Develop over time
Does this difficulty impact the client's daily life?	□ No □ Yes If yes, please describe:		
Overall, I would rate the client's communication as:	☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Communication history and current status (check all that apply to the client)	☐ My communication problem interferes with my social activities ☐ My communication problem interferes with my performance at work ☐ My communication problem interferes with my home life ☐ My voice does not reflect the "true me" ☐ My voice difficulties restrict my social life ☐ I feel anxious when I know I have to use my voice or communicate ☐ I have difficulty recalling the names of common objects, people, or places ☐ My communication is not easily understood by people I know ☐ My communication is not easily understood by strangers ☐ I frequently say the wrong sounds in words ☐ I am concerned about how well people understand or perceive my voice or speech ☐ My speech contains many word repetitions or prolonged sounds ☐ I often run out of breath while talking ☐ It takes a great amount of effort to talk; I have to concentrate to make my voice sound the way I want or communicate the way I want ☐ I have difficulty reading ☐ I have difficulty learning and remembering new information ☐ I have difficulty remembering things that I need to do, such as appointments or tasks for work ☐ I have difficulty paying attention while having a conversation or completing a task ☐ I have difficulty thinking through problems to find solutions ☐ Other:_____		
What are the client's goals for communication? What would they like to be able to do better?	_____ _____ _____		

Hobbies/Interests:

What are the client's hobbies and/or special interests?	
What organizations does the client participate in (church, community, etc.)?	

Computer Skills:

Describe the client's computer and any other digital devices that they know how to operate:	
Does the client's computer have video and audio connections?	□ No □ Yes
Does the client have internet access?	□ No □ Yes
How many years has the client used computers?	_____

Additional Comments:
Please use the space below to share any additional comments or information that you feel the diagnostic team could benefit from knowing.