COLORADO SPEECH THERAPY SERVICES

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Adult History Form

Date form completed: ___________________

Name of Person Completing this Form: ____

Relationship to Client: ____

Client's Name: _____________________________________Birth Date: _______________ Age: _________

Primary Language: ________________________ Secondary Language: _____________________________

Address:____

Home Phone: ____________________________Alternate Phone: __________________________________

Referral Source: ____________________________ Primary Physician: _____________________________

Reason for referral: ____

____

What information do you hope to obtain from this evaluation? ______________________________________

____

____

Medical History

Diagnosis: ____Date of onset or diagnosis: _________________

Please describe the speech/language difficulties: ____

____

____

Has the speech/language problem changed since first diagnosed? Please describe: ____________________

____

Hospitalizations: ____

Dates: ____

Hospital(s): ____

Reason(s): ____

Test(s) completed: (Please circle those that apply.)

MRI   CT Scan   Chest X-Ray   Other: ____________________

Do you have any difficulty eating or drinking?   Yes   No

If yes, please explain: ____

____

Previous Medical History: (Circle all that apply)

Headaches   Dizziness   Encephalitis   Hearing Loss   Pneumonia   Seizures   PEG Tube

Diabetes   Hypertension   Respiratory Issues   Cardiac Issues   CVA/Stroke (Date: ____________)

Head Injury (Date:______________) Other: ____________________

Do you have problems with hearing or vision?   Yes   No

If so, please explain: ____

Do you wear glasses?   Yes   No

Hearing Aid(s)?   Yes   No

Have you ever been referred to any of the following specialists? (circle those that apply)

Audiologist   ENT   Gastroenterologist   Neurologist   Internal Medicine

Occupational Therapist   Physical Therapist   Speech Therapist

If yes, please state the reason and results:____________________

____

____

List any current medications and what they are prescribed for:

____

____

____

____

Educational History

Highest grade completed: ____________________________Degree(s): ______________________________

Have you ever had difficulty with the following areas prior to your illness or accident? (circle all that apply)

Understanding Attention Reading Memory Speaking Writing

Problem Solving Math

Work History

Currently Employed? Yes No Occupation: ____

Place of Employment: _________________________________Job Duties: ___________________________

____

If you are retired, for how long: ____

Are you currently driving? Yes No

What are your household responsibilities? (circle all that apply)

Cleaning Laundry Balancing Checkbook Grocery Shopping Cooking Child Care Yard Work Household Repairs Driving Other: ______________________________

Have you had to stop doing any of your previous activities? Yes No

If yes, what and why? ____

____

Please list any specific hobbies, interests, or social activities: ______________________________________

____

____

Family History

Spouse's Name: ____

Child(ren)'s Name(s): ____

____

Do you have any family history of speech/hearing problems? Yes No

Please explain: ____

____

Do you have any family/friends who can (or do) assist you throughout the day? Yes No

If no, are you using hired help? Yes No

Who:____

Any additional information you'd like to add: _______________________________________

____

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____

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Thank you