L.L. SCHENDEL
SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

Adult Case History Form - Speech & Language

Date: ___________________________

Circle service desired; Speech Therapy or Evaluation: Speech Language Fluency Voice AAC
Other:____

Demographic Information:
Client's Name: ________________________________ DOB: ________________ Age: ______________
Gender: Male ______ Female ______ Other ______ Primary Language: ____________________
Address: ____
Cell Phone: ______________________ Work Phone: _______________. (City/State/Zip)

Client Email Address: ____
Emergency Contact: ____ Phone#______________________
(Caregiver/Spouse/Significant Other)

Email of Emergency Contact____

Name & relationship of Person Completing the Form: ____

Insurance:
Do you have Medicare? ___YES ___NO Do you have Medicaid? ___YES ___NO

Name of Insurance Company: __________________________ I.D. Number: ___________________________
FSU AFFILLIATION: ___Student (TCC,FAMU, FSU, Other) _____Faculty/Staff/Alumni/Employee

Referring Physician or service: ____
Family Physician: ____
Reason for Referral or Services:
____
____
____

Medical History:
Date of Onset or Diagnosis: ____________________________________

Past Medical History:

Hospitalizations: Surgeries:

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Florida State University • 201 W Bloxham St • Tallahassee, Florida 32306
Telephone: 850.644.2238
Website: https: //csdclinic.cci.fsu.edu

Please check if you have ever had:

☐ Reflex Disease	☐ Asthma	☐ Colds	☐ Anemia
☐ Dizziness	☐ Osteoporosis	☐ Head Injury	☐ Reflux/GERD
☐ Headaches	☐ Ear Infections	☐ Encephalitis	☐ Other:
☐ Neurological Problems	☐ Pneumonia	☐ Heart Problem	________
☐ High Blood Pressure	☐ Pacemaker	☐ Seizures	________
☐ Developmental Delay	☐ Meningitis	☐ Lung Problems	________
	☐ Stroke	☐ Thyroid Problems	________
	☐ Cancer	☐ Lung Disease	________
	☐ Diabetes		________
			________

Please list your allergies:

Food:	☐ Environmental	☐ Medications	☐ Other:
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________

Tests Completed: (Circle all that apply)

MRI CT Scan Chest X-Ray Other: ________________________________

Do you have problems with hearing or vision? Yes _____ No _____

If yes, please explain.

____

____

____

Do you wear glasses? Yes _____ No _____ Do you wear hearing aids? Yes _____ No _____

Current Medications: ____

____

____

____

____

Speech/Language History:

Describe the speech/language difficulties:

Date of onset of speech/language difficulties: ____________________

Prior Speech and Language Services: Yes _____ No _____

If Yes, Please Describe: ____________________

If known, what is the cause of the speech/language difficulty: ____________________

Has the speech/language problem changed since first diagnosis? Please describe.

Have any members of your family had speech/language difficulties? Please describe.

How do you feel your speech/language difficulties have affected your social life?

If you are currently employed, how do you feel your speech/language difficulties have affected your occupation?

Do any specific communication situations present difficulty for you?

Do you avoid any communication situations? Explain.

____

____

Swallowing History:
Do you have any difficulty with eating or drinking? Yes _____ No ____
If yes, please describe the nature of the swallowing difficulty.

____

____

When did the swallowing difficulty start? ____

Has the swallowing difficulty gotten better or worse? Yes _____ No _____

If yes, please describe.

____

____

____

Does the swallowing problem happen with certain foods or liquids? Please describe.

____

____

____

Does the swallowing problem happen at different times of the day? Yes _____ No _____
If yes, please describe.

____

____

____

Have you had a video swallow study done in the past? If so, when? And what were the results?

____

____

____

Educational History:
Highest Grade Completed: ______________________________
Degree(s): ____

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

Understanding	Reading	Speaking	Writing
Attention	Memory	Problem Solving	Math

Family History:

Spouse/Partner's Name: ______________________________

Child(ren)'s Name(s): ______________________________ Age: ____________________

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

Do you have any family or friends who can (or do) assist you throughout the day?

____

Work History:

Currently Employed: Yes _____ No _____ Date of Retirement: ____________________

Occupation: ____

Job Duties:

____

____

____

Social History:

Are you currently driving? Yes _____ No _____

Are you able to perform the following activities of daily living? (Circle all that apply)

Dressing	Walking (Unassisted,	Feeding
Bathing	Cane, Walker, or	Grooming
Toileting	Wheelchair?)	Other: _______

Please list any specific hobbies, interests, or social activities?

____

____

____

____

Have you had to cease any of your hobbies, interests, or social activities? If yes, why?

____

____