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Adult and Adolescent Case History

Case History Information

Date: _____

Name:	
Address:	
Daytime Phone:	
Other Phone:	
DOB:	

Referral Source:	
What is/are your concern(s)?	
Name and Address of Physician:	

I. Personal History

Occupation:		Place of birth:	
1. Who lives in the home?			
Name	Age	Relationship?	

2. What languages are spoken at home?

3. Is there any history of speech or language problems in the family? YES NO
If yes, please describe.

4. Is there any history of hearing problems in the family? YES NO
If yes, please describe.

5. Describe any significant family medical, learning, or emotional history.

6. Have you seen any additional specialists? YES NO
If yes, please specify.

Name:

Address:

Phone number:

Name:

Address:

Phone number:

II. Medical History

1. Have you been hospitalized? YES NO
If so, include age, reason, and length of stay.

2. History of illness, including age.

3. History of accidents, including age.

4. How would you describe your general health?

5. Are you taking any medication? YES NO
If so, list medication(s) and reason why.

6. Have you had your hearing tested? YES NO
If so, when and what were the results?

7. Medical History: Check all that apply:

Frequent congestion	<input type="checkbox"/>	Mouth breather	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	GERD/Acid reflux	<input type="checkbox"/>
Frequent colds or upper respiratory infections	<input type="checkbox"/>	Frequent stomachaches	<input type="checkbox"/>
Frequent sore throats	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	Headaches	<input type="checkbox"/>

Ear popping	<input type="checkbox"/>	Ear infections (as adult)	<input type="checkbox"/>
Tinnitus (ear ringing)	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
Frequent nausea	<input type="checkbox"/>	Dry/bloody nose	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>
8. Dental History: Check all that apply:			
Cavities	<input type="checkbox"/>	Root canals	<input type="checkbox"/>
Gum disease	<input type="checkbox"/>	Excessive wear	<input type="checkbox"/>
Chipped tooth/teeth	<input type="checkbox"/>	Mouth sores (canker)	<input type="checkbox"/>
Mouth sores (herpes simplex)	<input type="checkbox"/>	Halitosis (bad breath)	<input type="checkbox"/>
Gingivitis	<input type="checkbox"/>	Inflamed gums	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	Excessive plaque	<input type="checkbox"/>
Teeth grinding	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>
Wisdom teeth extraction	<input type="checkbox"/>	Orthodontia	<input type="checkbox"/>
9. Have you had other dental problems not indicated in the dental history? YES <input type="checkbox"/> NO <input type="checkbox"/>			

III. Functional Information

1. Do you have any feeding difficulties or history of feeding issues as a child (i.e., drooling, swallowing, etc) YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Do you avoid any foods? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Do you have any oral habits (i.e., nail biting, lip licking, chewing objects, thumb/finger sucking)? YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Were you a picky eater? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Do you grind or clench your teeth? YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Do you breathe through your nose with your lips sealed? YES <input type="checkbox"/> NO <input type="checkbox"/>
7. What time do you go to sleep?

8. When you sleep, do you..... Select all that apply

Snore	<input type="checkbox"/>	Drool	<input type="checkbox"/>
Wake up with head or jaw pain	<input type="checkbox"/>	Wake frequently*	<input type="checkbox"/>
Feel tired all day	<input type="checkbox"/>	Sleep walk	<input type="checkbox"/>
Have night terrors	<input type="checkbox"/>	Restless legs	<input type="checkbox"/>
Restlessness/tossing and turning	<input type="checkbox"/>	Light sleeper	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	Sleep talk	<input type="checkbox"/>

***If you checked off "wake frequently," how often do?**

9. What time do you wake up?

10. Do you have any sensory issues, such as sensitivity to smell, light, and touch? YES
NO

11. Do you have any balance or coordination difficulties? YES NO
If so, please describe.

12. How clear do you feel your speech is? Do you feel like you "mumble" sometimes?

IV. Social History

1. How would you describe your personality?

2. Do you smoke or drink? YES NO

If yes, circle the following: SMOKE or DRINK

3. Do you have any embarrassment or anxiety about your current condition? YES NO

V. Is there any other information about you that may be helpful in this evaluation?
(Explain)