NYCSPEECH-LANGUAGE PATHOLOGIST

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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	☐	Mouth breather	☐
Allergies	☐	Heartburn	☐
Asthma	☐	GERD/Acid reflux	☐
Frequent colds or upper respiratory infections	☐	Frequent stomachaches	☐
Frequent sore throats	☐	Constipation	☐
Difficulty swallowing	☐	Headaches	☐

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

III. Functional Information

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

8. When you sleep, do you….. Select all that apply			
Snore	☐	Drool	☐
Wake up with head or jaw pain	☐	Wake frequently*	☐
Feel tired all day	☐	Sleep walk	☐
Have night terrors	☐	Restless legs	☐
Restlessness/tossing and turning	☐	Light sleeper	☐
Difficulty falling asleep	☐	Sleep talk	☐
***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. <u>Is there any other information about you that may be helpful in this evaluation? (Explain)</u>