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Certified Speech/Language Pathologist
Listening and Spoken Language Specialist

CASE HISTORY

Identifying Information

Name______________________________ Date of Birth______________ Today's Date_____________

Address____

Street City State Zip

Preferred
Phone____________________ AlternatePhone________________ email___________________________

Age________ Sex_____ Race (optional)________ Marital Status_____________ SS#_______________

Referred by (phone #, if avail.)____

Occupation_____________________________ Employer____

Family
Physician___________________________ Address____

Name of Spouse or Nearest Relative____

Address____

Street City State Zip

Phone Number___________________________ Employer____

Insurance Information

Medical Insurance Company____

Address____

Street City State Zip

Group or Policy #__________________ Name of Policy Holder____________________________________

Policy holder's social security#____

Description of The Problem

Please answer the following questions as completely as possible. Use the back of the sheet, if necessary. Describe the nature of your problem.______________________________________

____

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Arlington, Texas 76016
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Under what circumstances is this problem most troublesome?_______________________________

____

How long have you had the problem? When was it first noticed?____________________________

____

Did it develop suddenly? Slowly? Explain.____

____

What do you regard as the cause of the problem?____

____

Family and Medical History

Do any other members of your family have a voice, speech, or hearing problem? Explain.__________

____

Names, relationship and age of others living in your home___________________________________

____

Please check any condition you now have or have had in the past.

____Frequent Colds	____Sinus Problems	____Skin Disease
____Earaches	____Hearing Loss	____Tumor
____Inhalant Allergies	____Vision Problems	____Diabetes
____Medication Allergies	____Voice Problems	____Rheumatism
____Lung Disease	____Slurred Speech	____Arthritis
____Kidney Disease	____Stuttering	____Chronic Indigestion
____Influenza	____Learning Disabilities	____Meningitis
____Asthma	____Memory Loss	____Scarlet Fever
____Pneumonia	____Cancer	____Polio
____Pleurisy	____Stroke	____Tuberculosis
____Bronchitis	____Paralysis	____Epilepsy
____Chronic Cough	____Head Injury	____Mumps
____Hoarseness	____Heart Disease	____Tremor
____Enlarged Glands	____Convulsions	____Food Allergies
____High Fever	____Bowel and Bladder Disease	
____Headaches		
____Hernia		

Are you taking any medications?____

____

Have you ever had surgery?__________ Date and Results:______________________________

____

Do you smoke?_________________How much?________________For how long?___________

Describe your present health status:____

____

____

Previous Evaluations or Therapy

Have you previously had evaluations for speech, voice, or hearing disorder? If so, when and by whom?____

____

Have you previously been enrolled in speech therapy? If so, describe the nature and result of the therapy____

____

Please note any additional information you feel is pertinent to your case.____________________

____

____

What would you like to learn from this evaluation?_______________________________________

____

____

This form was completed by:____

Relationship to patient:____