Adult Confidential Case History Questionnaire

Today's Date:		
Patient Name:		Date of Birth:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Business Phone:
Email Address:		
Person to contact in an emergency:		
Physician/Pediatrician:	Phone:	
Medical Diagnosis:		
Other Physician's/Specialist/Professionals working with your child:		
Name:	Phone:	
Name:	Phone:	
Name:	Phone:	
Referral Information:		
Referred By:		
Describe your concerns and goal :.		
Have you received any interventions or services up to this date? Please explain:		
Medical History		
Have you experienced any history of the following? If yes please explain and give dates.		
Childhood diseases or major illnesses?		
Surgery?		
Serious Injury?		
Cast or braces?		
Allergies?		
Frequent ear infections?		
Dietary restrictions?		

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Medical conditions that may be pertinent (check all that apply)
Allergies
Hearing Loss
Excessive Mucus
Medications
Previous Intubation
Thyroid Condition
Frequent Infections
Psychological Problems
Bulimia
Deviated Septum
Craniofacial Anomalies
Trauma
Mouth Breathing
Surgeries
Dryness of Tract
Reflux
Enlarged Tonsils and Adenoids
Sleep Apnea
Other:
Abusive practices (check all that apply)
Throat Clearing
Excessive Talking
Loud Talking
Smoking
Sound Imitations
Gargling
Muscle Tension
Coughing
Loud Singing
Yodeling
Impersonations
Drug Abuse
Other:
Demands inherent in life-style environment (check all that apply)
Fatigue
Cheerleading
Stress
Dramatics
Noisy Environment
Choir
Solo Singing
Sporting Activities
Other:

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General physical development and health. Is there a history of:		
	Yes	**No**
Allergies		
PMS		
Hormone Imbalance		
Trauma		
Serious Illness		
Chronic Sinusitis		
Dysphagia		
Tracheostomy		
Eat Disease		
Incoordination of Face or Tongue Muscles		
Gait Peculiarities		
Tremor		
Velopharyngeal Problems		
Surgeries/Intubation		
Bulimia		
Sleep Apnea		
Neurologic Disease		
CVA		
Arthritis		
Alcoholism		
Dementia		
Paralysis/Paresis		
Smoking		
Broken Nose		
Mouth Bleeding		
Gastro-Esophageal Reflux		
Unusual Sexual Development		
Heart/ Circulatory Problems		
Other:		
Are you currently taking any medications? If yes, please list medications by name and state what condition the medication is treating?		
Have you ever had a psychological, developmental, neurological, psychiatric, or EEG/MRI evaluation? If so why and what were the results?		

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Fluency
Do you stutter or stammer?
How long have you observed dysfluencies?
Voice
Does your voice exhibit any of the following qualities? Circle all that apply
Hoarse harsh nasal very soft very loud other
Has the speaker had voice therapy?
If yes what was the nature of the therapy?
What were the results of therapy?
Feeding
Have there been any feeding problems?
Any problems with sucking, chewing, choking, or swallowing?
Social Development
Describe any social problems you have with friends and family:
How do you relax?
Sensory History
Date of last hearing evaluation?
Who performed the test? Result of test:

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I understand that I am responsible for payment in full at the time of evaluation/therapy. Unless other arrangements have been made in advance and approved by the clinical director at Frankly Speaking SLP, Inc.

Please print name: _____

Signature: _____

Relationship to Patient: _____ **Date:** _____