



Speech & Language Stimulation Center, Inc.  
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## Speech & Language Stimulation Center, Inc.

### Case History Form – Adult

(The information supplied on this form will be confidential. It will help us to appropriately prepare for our evaluation. We can also discuss any information at the time of the appointment. Usually testing takes about an hour and we like to discuss our impressions with you or demonstrate some things to you for 15-30 min thereafter.) \*\*\*\*please fill out each line or put n/a if not relevant\*\*\*\*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Name of person who is filling out form (if different from above): \_\_\_\_\_

Relationship to the adult seeking therapy: \_\_\_\_\_

NAME of SPOUSE/PARTNER or PARENT (if living with parent): \_\_\_\_\_

Highest level of school completed: \_\_\_\_\_

Current school (if applicable): \_\_\_\_\_

Do you have an IEP or receive support services from community agencies (e.g., Foothills Gateway)?

Describe your main concern; why are you seeking an evaluation at our Center? (Please be specific)

Describe any significant personal or family history related to your main concern: \_\_\_\_\_

How did you find out about our practice? \_\_\_\_\_

Who is your main doctor? \_\_\_\_\_

A copy of your initial evaluation report will be sent to the referring physician; is this ok? \_\_\_\_\_

Do you want a report sent to anyone else? \_\_\_\_\_ To whom? (A release of information needs to be signed)

Have you previously received therapy services that you would like us to know about? (occupational, physical, vision, speech, music therapy, counseling) \_\_\_\_\_

### MEDICAL HISTORY

How is your current health? \_\_\_\_\_

Do you have a medical diagnosis? (list all that might be appropriate for us to know) \_\_\_\_\_

Describe any pertinent illnesses/ accidents/ hospitalizations \_\_\_\_\_

Are you currently receiving any medical treatment or on medication?

Do you have any allergies/asthma? \_\_\_\_\_

Sometimes there is a therapy dog in the office – would this be a problem? \_\_\_\_\_

Has your hearing been tested in the last two years? \_\_\_\_\_ By whom and when? \_\_\_\_\_

Results of hearing tests: \_\_\_\_\_

Describe any visual impairments, corrections, vision therapy, etc. \_\_\_\_\_

What would be your primary goals for us to keep in mind? \_\_\_\_\_

Do you have any additional information you would like us to know? \_\_\_\_\_

**Directions to Speech & Language Stimulation Center, Inc.:**

