Speech & Language Stimulation Center, Inc.

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Case History Form – Voice

(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 person seeking therapy:____

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

Highest level of school completed: ____

Current school (if applicable):____

Describe your main concern; why are you (or your child) 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 ____

____

____

Your name: ________________________________

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? ___________________________________

____

Voice, vocal cord/fold dysfunction, coughing clients please continue filling out the attached “judging your own voice” sheet