Adult Case History Form

Name of Person Completing this Form: ____

Relationship to Client: ____

- -

Client's Name: ______________________________ Birth Date: __________ Age: _________

Address: ____________________________________

____

Home Phone: _______________________________ Alternate Phone: ______________________

Referring Physician: __________________________ Family Physician: ____________________

Primary Language: ___________________________

Reason for referral: ____

What information do you hope to obtain from this evaluation?______________________________

____

Medical History

Date of onset or diagnosis: __________________________________

Please describe the speech/language difficulties:

____

____

____

If known, what is the cause of the speech/language difficulty?

____

Terri Rossman, *M.S., CCC, Director* ♦ Mary Ann Raymond, *M.S., CCC, Associate Director*
133 Wall Street, Princeton NJ 08540 ♦ Tel: 609-924-7080 ♦ Fax: 609-924-6563 ♦
info@psllcnj.com ♦ www.psllcnj.com

Has the speech/language problem changed since first diagnosed? Please describe.

____

____

Hospitalization:

Dates:	Hospital(s):	Reason(s):
________________	______________________	_____________________
________________	______________________	_____________________
________________	______________________	_____________________
________________	______________________	_____________________
________________	______________________	_____________________

Test(s) completed: (Please circle those that apply.)

MRI CT Scan Chest X-Ray Other: _________________________

Do you have any difficulty eating or drinking? ________________________________

Previous Medical History: (Circle all that apply)

Headaches Dizziness Encephalitis Hearing Loss Pneumonia
Seizures PEG Tube Diabetes Hypertension Respiratory Issues
Cardiac Issues CVA (Stroke) (Date: ______) Head Injury (Date:_____)
Other: ____

Do you have problems with hearing or vision? Please explain:

____

Do you wear glasses? Yes No Hearing Aid(s)? Yes No

Have you ever been referred to any of the following specialists? (circle those that apply)

Audiologist Otolaryngologist (ENT) Gastroenterologist Neurologist
Psychologist Psychiatrist Occupational Therapist Physical Therapist

If yes, please state the reason and results: _________________________________

____

List all current medications and what they are prescribed for:

____

____

____

Have you ever been evaluated by or had treatment with a Speech Language Pathologist?
Yes No When?________ Reason/ Results? ____

____

____

Educational History

Highest grade completed: ________________________________
Degree(s): ____
Name of Institution: ____________________________________
Have you ever had difficulty with the following areas prior to your illness or accident?
(circle all that apply)

Understanding Reading Speaking Writing Math
Attention Memory Problem Solving

Work History

Currently Employed? Yes No Date of Retirement? _________________________________
Occupation: _________________________________
Place of Employment: _________________________
Job Duties:

____

____

Are you currently driving? Yes No

What are your household responsibilities? (circle all that apply)

Computer tasks Balancing Checkbook Grocery Shopping Cooking
Cleaning Child Care Yard Work Household Repairs
Laundry Driving Other: _______________________________

Have you had to stop doing any of your previous activities? If yes, what and why?

____

____

Please list any specific hobbies, interests, or social activities: ______________________________

____

Family History

Spouse's Name: _______________________________________

Child(ren)'s Name(s): ___________________________________ Age: _______________

___________________________________ Age: _______________

___________________________________ Age: _______________

___________________________________ Age: _______________

Do you have any family history of speech/hearing problems? Yes No

Please explain: ____

Do you have any family/friends who can (or do) assist you throughout the day?

____

Cancellation Policy

Princeton Speech-Language and Learning Center is dedicated to providing quality services to our clients. We must stress that consistency of attendance is crucial in order for clients to effectively meet the goals of their treatment plan. In addition, therapy time is specifically reserved for your family and is unavailable for other clients.

We are sensitive to the needs faced by the families of our clients however; it is necessary for us to enforce a cancellation policy. Except in cases of emergency or sudden illness, appointments not cancelled **48 hours** in advance will result in a charge as though the appointment was held.

We look forward to a positive relationship with you, as we strive to provide cutting edge, quality treatment and specialized programs. Thank you for your attention to this matter.

Signed: ___________________________________

Date: ________________

FINANCIAL RESPONSIBILITY

I hereby agree to accept full responsibility for all fees for services rendered to the patient by the practitioner. I am also aware of the cancellation policy enclosed.

Signed: _______________________________________ Date: ____________________

Driver's License Number: __N J___________________

CLINICAL RELEASE OF INFORMATION

Mr.
Mrs.
I, Ms. ______________________________, hereby give Princeton Speech-Language & Learning Center permission to discuss my case with the interdisciplinary professionals involved in my care, and to release any relevant clinical information to those professionals if requested. I also authorize PSLLC to release and/or share any information requested by my insurance company.

____
(Client's Name)

Name: ___________________________

Address: ________________________

____

Phone: ___________________________

Name: _________________________

Address: _______________________

____

Phone: _________________________

Signature of Patient: ___________________________________ Date: _______________

Document must be signed by parent or guardian if patient is under 18 years of age.