WHITEFISH THERAPY & SPORT CENTER

SPEECH • PHYSICAL • OCCUPATIONAL • REHABILITATION • TRAINING

406-862-WFPT(9378)

ADULT CASE HISTORY FORM: SPEECH-LANGUAGE PATHOLOGY

Patient Name: _____ **Date of Birth**: ____/____/____**Date:** ____/____/20___

Person filling out this form (circle one): Self Other (Relationship to Patient): _____

Would you like to receive text or email reminders of appointments? ☐ **Yes** ☐ **No**

If yes, please provide cell phone provider <u>and</u> phone number or email address: _____

<u>MEDICAL HISTORY:</u> please check all that apply. Please provide the dates where applicable

- ☐ Heart attack
- ☐ Heart troubles
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Chronic laryngitis
- ☐ Acid reflux/GERD
- ☐ Ear infections
- ☐ Meningitis
- ☐ Seizures
- ☐ Head injury
- ☐ Neurological conditions
- ☐ Allergies
- ☐ Cancer
- ☐ Head/neck cancer
- ☐ Shingles
- ☐ Bronchitis
- ☐ COPD
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Arthritis
- ☐ Hearing loss
- ☐ Cerebral palsy
- ☐ Intellectual deficits
- ☐ Cleft palate
- ☐ Chronic colds
- ☐ Facial nerve palsy
- ☐ Emotional or psychological issues
- ☐ Multiple sclerosis
- ☐ Huntington's or Parkinson's Disease
- ☐ Voice issues or changes
- ☐ Vocal polyps or nodules

Have you been hospitalized within the last 5 years? If so, why? Where?

_____

_____

What is your current state of health?

☐ Excellent ☐ Average-fair ☐ Poor

Medications: Please list your current medications or attach list to be scanned, including: over the counter medications, vitamins/mineral/dietary supplements, prescription medications and any herbal supplements:

	Name of Medication	**Dosage**	**Frequency**	**Route of Administration (e.g., oral, IV, etc)**
1				
2				
3				
4				
5				
6				
7				

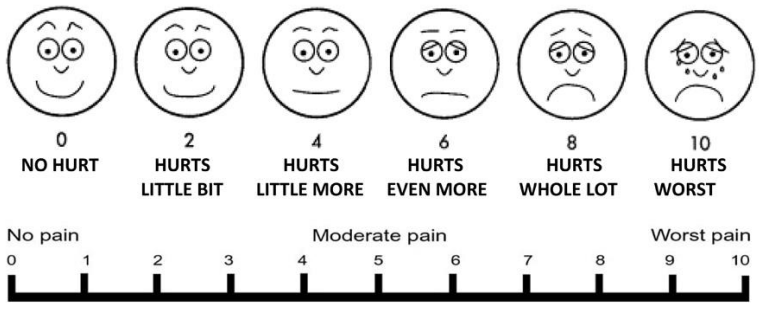
Pain:

Do you have pain? ☐ Yes ☐ No

If yes, please list where: _____

Using the pain scale provided, please rate the amount of pain you have right now: _____ of 10

Using the pain scale provided, please rate your pain where it is at its worst: _____ of 10



Smoking:

Do you currently use tobacco or tobacco products? ☐ Yes ☐ No

If yes, what type and how frequently: _____

Alcohol Use:

How many times in the last year have you had 4 or more drinks? _____

SPEECH-LANGUAGE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty swallowing liquids, food or pills			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Difficulty with orientation/memory			
Difficulty with problem solving			
Difficulty managing your own schedule			
Difficulty focusing/attention			
Difficulty with reading/writing			
Difficulty finding words			
Difficulty maintaining topic of conversation			
Stuttering			
Difficulty following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			
Other:			

When was this problem first noticed?

_____

_____

Does this speech-language-cognitive difficulty impact your ability to function in daily life?

_____

_____

How or where does the speech-language-cognitive difficulty impact you the most?

_____

_____

What do you hope to get out of speech-language therapy?

_____

_____

Have you been seen by any other rehabilitation professionals?

☐ **Speech therapy**: When: _____ Where: _____

☐ **Physical Therapy**: When: _____ Where: _____

☐ **Occupational Therapy**: When: _____ Where: _____

☐ **Other**: _____

_____

SOCIAL AND EDUCATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse or partner's name:

_____

Children's names/ages:

_____

_____

Highest level of education (grade or degree) completed.

_____

_____

Current and/or Prior Occupation

_____

_____

Please provide other information you believe to be helpful in the development of your care here with us at Whitefish Therapy and Sport Center. Thank you.

_____

_____

_____

_____

_____

_____

Patient signature Date