Speech Case History Form
Adult

Name

First | Last

Date of Birth

MM/DD/YYYY

Home Address

Street Address

City | State | Zip Code

Home Phone

Alternative Phone

Job Information

Employer

Occupation | Business Phone

Referred by

Name | Phone

Street Address

City | State | Zip Code

Family Physician

Name | Phone

Street Address

City | State | Zip Code

Marital Status

☐ Single ☐ Widowed ☐ Divorced ☐ Married

Spouse's Name

Children

Name	Gender	Age
Name	Gender	Age
Name	Gender	Age

Who lives in the Home?

What language(s) do you speak? Which is your dominant language?

What was the highest grade, diploma or degree you earned?

GENERAL INFORMATION

Describe your speech-language problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed? ☐ Yes ☐ No
If yes, please describe below:

Have you seen any other speech-language specialist? ☐ Yes ☐ No
If yes, for when and how long?

What were their conclusions or suggestions?

Have you received any speech therapy while homebound? ☐ Yes ☐ No

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc)? If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions. ☐ Yes ☐ No

Are there any other speech, language or hearing problems in your family? ☐ Yes ☐ No
If yes, please describe:

MEDICAL HISTORY

Provide the approximate ages at which YOU suffered the following illnesses and/or conditions:

☐ Allergies	☐ Ear Infections	☐ Influenza	☐ Pneumonia
☐ Asthma	☐ Encephalitis	☐ Mastoiditis	☐ Seizures
☐ Colds	☐ Headaches	☐ Meningitis	☐ Sinusitis
☐ Dizzines	☐ Hearing Loss	☐ Noise Exposure	☐ Tinnitus
☐ Draining Ear	☐ High Fever	☐ Otosclerosis	☐ Other _____

Do you have any eating or swallowing difficulties? ☐ Yes ☐ No
If yes, please describe:

List all medications you are taking:

Are you having any negative reactions to these medication? ☐ Yes ☐ No
If yes, please describe:

Describe any major surgeries, operations or hospitalizations and when they occurred:

Describe any major accidents and when they occurred:

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation process:

Person completed this form

Relationship to patient

Signature

Please return this packet of information by mail prior to the evaluation, if possible, so the therapists can review and prepare the necessary evaluation. If it is not possible to return these prior to the evaluation, please bring them with you on the day of the evaluation.

Please mail this form to us as soon as possible:

Without Limits Speech Therapy
2400 Valley Avenue, Suite 9
Winchester, VA 22601

If it's not possible to mail this form, please be sure to bring it with you to the evaluation.

Thank you for taking the time to fill out this important information.