


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

Speech/Language - Adult Case History Form

Name _____ Date _____

Date of Birth _____ Age _____ Pronouns _____

Address _____

_____

Phone _____ Alternate Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address _____

Insurance:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

Subscriber Phone Number & Address _____

Occupation/Former Occupation _____ Employer _____

Highest Level of Education Completed _____

Name of Spouse or Nearest Relative _____

Native Language _____ Primary Language _____

Physician's Name _____ Phone _____

Referred By _____

Person Completing this Form _____ Relationship _____

COMPLAINT

1. Why do you wish to be evaluated at our clinic? Please describe your communication problem.

_____

_____

2. What would you hope to gain through the use of our services?

_____

_____

3. When and where did you have previous communication therapy? Please describe:

_____

_____

4. Are there any particular times of the day or situations in which your problem is worse? If so, please describe:

5. Are there any particular times of the day or situations in which your problem is better? If so, please describe:

6. Have any other members of your family had a communication problem? If yes, please describe:

7. Have you ever experienced any of the following? Please check.

	Approximate Date(s) Year	
_____	_____	Difficulty saying the sounds of English
_____	_____	Difficulty recalling the words you wish to say
_____	_____	Voice problems
_____	_____	Hearing problems

MEDICAL

1. Have you had any recent or prolonged illness? If so, please describe:

2. Are you presently taking any medication? If so, please list and indicate reason for taking them.

3. Describe any surgery you have had. Indicate year of surgery.

4. Describe any significant accidents you have had and indicate dates.

5. Have you ever had any of the following? Please check.

	Approximate Date(s) Year			Approximate Date(s) Year	
_____	_____	Influenza	_____	_____	Scarlet fever
_____	_____	Heart disease	_____	_____	Meningitis
_____	_____	Weakness of arms or legs	_____	_____	Allergies
_____	_____	Uncontrolled trembling	_____	_____	Sinus problems
_____	_____	Difficulty in swallowing	_____	_____	Frequent colds
_____	_____	Shortness of breath	_____	_____	Thyroid problems
_____	_____	Measles	_____	_____	Other (please describe)