Altruistic
THERAPY SERVICES

PLEASE NOTE A SCRIPT MUST BE PROVIDED FROM YOUR PCP BEFORE THE EVALUATION:
I understand and will obtain one or my evaluation will be cancelled, and I will owe a $50.00 cancellation fee: **Initial to confirm you understand this**: _____

Case History Form-Adult General Information **Date:_____**

Name: _____ Date of Birth: _____
Address_____ City: _____ Zip:_____
Home phone: _____ Daytime phone: _____Cell: _____
Spouse/partner's name: _____
Emergency Contact and number: _____Occupation: _____
Single: _____ married: _____ divorced: _____widowed: _____
Children (names, ages):_____
_____
_____

Date of injury, accident, incident or first noticed symptoms (must have a month day and year):
MONTH: _____ DAY: _____ YEAR: _____ If Auto accident, date of accident: _____

Referring physician: _____ Address: _____
City: _____ Zip: _____ Phone: _____

What are your goals for coming to the clinic at this time?
_____
_____

Any surgeries related to the issue? If so what surgery and when was the surgery performed:
_____

Were you hospitalized as a result of your diagnosis or injury? _____When:_____

Have you seen any other speech-language specialist(s)? Who and when? What were their conclusions or suggestions?
_____
_____

How do you feel your problem has affected your social life, career, education, etc.?

_____

_____

Have you seen any other specialist (physical/occupational therapists, surgeons, physicians, psychologists, neurologists, etc.) concerning your problem? If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

_____

_____

Medical History:

Please check the following if they apply:
Cancer: _____(where: _____ COPD:_____ Intubation / ventilation:_____
Tracheostomy: _____ Cardiac concerns: _____Hearing Loss _____ Allergies _____ GERD/Reflux _____ Noise Exposure _____ Dizziness _____ Infections _____ Encephalitis _____ Depression _____ Seizures _____ High Fever _____ Head Injury _____ Otosclerosis _____ Meningitis _____ Stroke _____ Sinusitis _____ Measles/Mumps_____ Concussion _____ Tinnitus _____ Mastoiditis _____ Headaches _____ Pneumonia _____ Chronic Cough _____ Anxiety _____ Asthma _____
Difficulty Breathing _____ Voice Problems _____ HIV: _____ MRSA: _____
Emotional/Psychological:_____ Neurological disorders: i.e.: MS, Parkinson's ETC: _____

Is there a history of:
Smoking _____ How much per day? _____
Drinking _____ How much per day? _____

Do you have any eating or swallowing difficulties? If yes, please describe.

_____

_____

_____

List all medications and the purpose for each. Please use the back if you need more room.

_____

_____

_____

_____

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Describe any major surgeries or hospitalizations (including dates).

_____
_____
_____
_____

Describe any major accidents.

_____
_____
_____
_____

In the space below, please provide any additional information that might be helpful in the evaluation or treatment process.

_____
_____
_____
_____
_____
_____

Person Completing Form: _____
Relationship to Client: _____
Signature: _____Date: _____