

**SPEECH, LANGUAGE & COMMUNICATION
ADULT HISTORY FORM**

Client's Name _____ Today's Date _____
Date of Birth _____
Name of person completing this form (if different than client) _____
Client's Occupation _____
Client's Educational Background _____
Client's Primary Language _____
Client's Primary Care Physician _____

1. Please indicate what your specific concern(s) is/are: *(please check)*

- | | | | |
|---|--|--|--------------------------------|
| <input type="checkbox"/> Speech Articulation | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Chewing | <input type="checkbox"/> Voice |
| <input type="checkbox"/> Stuttering | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Other |
| <input type="checkbox"/> Expressing Yourself | <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Dentition | |
| <input type="checkbox"/> Understanding Others | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Tongue Thrust | |
| <input type="checkbox"/> Reading/Writing/Math | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Head/Trunk
Muscle Weakness | |

Please describe your concerns

2. How long have you had this concern?

3. What questions would you like answered at your appointment?

4. Describe how your specific concerns affect you in your daily life:

5. Have you had any speech therapy or other intervention in the past? If so, when?

What areas of difficulty were addressed in therapy?

Name of therapist _____ Phone number _____

6. Do any of your family members have a history of speech, language, hearing, or learning difficulties? If so, please describe:

7. Do you use a nonverbal form of communication? If so, please describe:

8. Medical History

a. Please indicate whether you have experienced any of the following: (*please check*)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Noise Exposure | <input type="checkbox"/> Enlarged Adenoids |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Reflux | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Upper Respiratory Infection | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dental Problems | |

b. Other illnesses:

c. Please list any significant injuries you have suffered and the dates on which they occurred:

d. Please list any significant surgeries you have had and the dates on which they occurred:

e. Please list any medications you are currently taking:

Complete the following section only if you are experiencing difficulty with your voice

1. Describe the feelings you are experiencing in your throat: (*please check*)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Loss of Voice | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Difficulty Singing | <input type="checkbox"/> Strain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tickling Sensation | <input type="checkbox"/> Other _____ |

2. Do you:

- | | | | |
|--|------------------------------|-----------------------------|------------------|
| Smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often? _____ |
| Drink caffeine products? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often? _____ |
| Sing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often? _____ |
| Engage in activities that require a loud voice or yelling (e.g. acting, public speaking, teaching, cheering at sporting events)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | List activities- |

Complete the following section only if you are experiencing difficulties with stuttering

1. Describe the nature of your stuttering (e.g. repeating, getting stuck):

2. Do you avoid certain speaking situations? If so, please describe:

3. Are there times when your stuttering is better or worse?

THANK YOU!