

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

Client's Name \_\_\_\_\_ 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 is: *(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

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2. How long have you had this concern?

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

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

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

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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?  Yes  No How often? \_\_\_\_\_

Drink caffeine products?  Yes  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!