CLEVELAND Hearing & Speech CENTER℠

11635 Euclid Avenue · Cleveland, OH 44106 · 216-231-8787 · 216-231-7141 Fax
4257 Mayfield Road · South Euclid, OH 44121 · 216-382-4520 · 216-325-7609 Fax
7000 Town Centre Drive #200 · Broadview Heights, OH 44147 · 440-838-1477 · 216-325-7620 Fax

SPEECH-LANGUAGE PATHOLOGY ADULT CASE HISTORY FORM

Client Name: _____ **DOB:** _____ **Sex:** ❑ Male ❑ Female

Statement of Problem:
Please tell us what you hope to learn during this appointment at CHSC:

What concern(s) do you have with your communication skills at this time?

When did this problem begin? (please give a specific date if possible)

What do you think caused this problem?

Have any other professionals diagnosed a specific problem? ❑ Yes ❑ No
If yes, please describe:

Please describe how you speech problem has affected your:

Daily Activities:
Occupation:
Socialization:
Other:

If you did not have this speech problem, how would your life be different; what could you do that you cannot do now?

Are you able to:
Provide all self care? ❑ Yes ❑ No
Complete your own typical daily activities? ❑ Yes ❑ No
Manage your own finances? ❑ Yes ❑ No
Please explain any item(s) above marked "no":

Educational History:
Years of School Completed/Degree: _____
School Attended: _____
Employer/Occupation: _____

Family Background:

Name(s) of Others Living with Client	Age	Sex	Relationship
		M F	
		M F	
		M F	
		M F	

Is there a family history of speech, language, and/or hearing difficulties? ❑ Yes ❑ No
If yes, note the person's relationship to the client and what type of difficulties they had:

Please continue on back of form

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Medical History:

My health is currently: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please check all items that apply. Explain all checked items below:

Item	When Occurred	Change in Abilities
❑ Allergies		
❑ Asthma		
❑ Attention Deficit Disorder (ADD)		
❑ Attention Deficit Hyperactive Disorder (ADHD)		
❑ Autism Spectrum Disorder (ASD)		
❑ Cancer		
❑ Chronic Colds		
❑ Emphysema		
❑ Head or Neck Trauma		
❑ Hearing Problem		
❑ Heart Problem		
❑ Hormonal Imbalance		
❑ Hypertension (high blood pressure)		
❑ Laryngitis		
❑ Psychological Disorder		
❑ Seizure Disorder		
❑ Sore Throat		
❑ Stroke		
❑ Tonsillectomy		
❑ Tuberculosis		
❑ Other:		

Please list your hospitalization/surgical history below: ❑ N/A if never hospitalized

Hospitalization/ Surgery	Date(s)

Has your hearing been tested? ❑ Yes ❑ No **If yes, please bring a copy of the hearing test results to your appt.**

If yes, where was the test completed? _____Date Completed?_____

Results of the hearing test: ❑ Hearing within normal limits ❑ Hearing loss ❑ Further testing required

What hand do you use for writing, eating, etc.? ❑ Left ❑ Right

Person Completing this Form**:** _____

Relationship to Client**:** _____ Date Completed: _____