**NEW PATIENT PAPERWORK: ADULT CASE HISTORY**

**GENERAL INFORMATION:**

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| Name (Last, First, MI): | | | | Birthdate (MM/DD/YYYY): | |
| Spouse / Partner’s Name: | | | | | |
| Home Address: | | | | City / State / Zip: | |
| Mailing Address (If Different): | | | | | |
| Email Address: | | | | | |
| Phone:  Home  Cell | | | | | |
| Primary Language(S) Spoken: | | | | | |
| Occupation: | | | | | |
| Employer: | | Work Phone: | | | |
| Referred By: | | Phone: | | | |
| Address: | | | | | |
| Family Physician: | | Phone: | | | |
| Address: | | | | | |
| Medical Diagnosis: | | | Date of Onset Of Diagnosis: | | |
| Allergies: | | | | | |
| Transportation:  Self  Public Transportation Relative / Friend  Other: | | | | | |
| Marital Status:  Single  Married  Widowed  Previously Married | | | | | |
| Children (Include Names, Genders, And Ages): | | | | | |
| Who lives in the home? | | | | | |
| Please describe your education history (degrees, institutions, year of graduation, grades received): | | | | | |
| Please describe your vocational history, listing all employment to the present: | | | | | |
| On Disability:  Yes  No | Applied for SSDI:  Yes  No | Workers Compensation:  Yes  No | | | Motor Vehicle Crash:  Yes  No |
| Please describe your speech-language and/or cognitive-communication problem in your own words: | | | | | |
| When did you begin having these problems: | | | | | |
| If you were involved in an accident, please describe the incident as completely as possible. Please be specific, e.g. speed of car, loss of consciousness (seconds, minutes, hours, days/coma, unknown): | | | | | |
| If you were off from school and/or work as a result of your injury/illness, please indicate length of time off. If you returned to work, were accommodations present? | | | | | |
| Have you had any treatment for your speech-language/cognitive-communication problems? If so, who did you see, for how long (give dates and include facility name): | | | | | |
| Have you seen any other specialists (physicians, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist’s conclusions or suggestions: | | | | | |
| Have you had any previous treatment for speech-language-cognitive-communication problems prior to injury/illness? If yes, please give dates and durations of treatment: | | | | | |

**NEUROMEDICAL HISTORY:**

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| Please indicate presence of any of the following conditions:  HEADACHES:  Back of head  Front of head  Side of head  Musculoskeletal  Craniomandibular/Temporomandibular  OLFACTORY PROBLEMS:  Diminishing taste and smell  VESTIBULAR / BALANCE PROBLEMS:  Dizziness  Vertigo  AUDITORY DISTURBANCE:  Tinnitus  Hearing Loss  Noise Sensitivity  VISUAL DISORDER:  Blurred vision:  Diplopia  Convergence & accommodation insufficiency  Light sensitivity  Sleep disturbances  Pain issues  Cognitive fatigue  Physical fatigue  Amnesia  Seizures  Convulsions  Tremors  Swallowing problems  Voice disorder  Dystonia  Tracheostomy |
| Please list any other medical conditions: |

**EMOTIONAL SEQUELAE:**

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| Please indicate presence of any of the following conditions:  Irritability  Anxiety  Depression  Personality change  Fatigue  Incoordination  Disinhibition  Desocialization  Avoidance of crowds  Low frustration tolerance  Loss of emotional control  Alcohol intolerance  Lethargy  Fluctuation in mood and behavior  Decreased libido  Eating disorders  Emotional liability (overreacts, cries easily)  Egocentrism  Impulsivity  Denial  Paranoia  Obsessive disorder  Lack of motivation  Social immaturity  Dependency  Excessive talking  Agitation |
| Please list any major surgeries, operations, or hospitalizations (indicate dates) since onset of present injury/illness: |
| Describe any major accidents: |
| List all medications you are taking (or provide a separate list): |
| Are you having any reactions to these medications? If so, please describe: |
| Have you received audiological testing? If yes, please indicate results, dates, and by whom: |
| Have you received ophthalmology testing? If yes, please indicate results, dates, and by whom: |

**COGNITIVE IMPAIRMENTS**

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| Have you had, or do you currently have, any difficulties in the following areas:  Memory difficulties  Impaired concentration and attention  Slowing of reaction time  Slowing of processing speed  Loss of judgement  Indecisiveness  Decreased ability to think abstractly  Difficulty learning new information  Organizational difficulties  Impaired executive functions (e.g. initiation, planning, sequencing, following through, etc) |

**COMMUNICATION IMPAIRMENTS**

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| Have you had, or do you currently have, any difficulties in the following areas:  Difficulty maintaining topic  Poor listening  Vague / unclear language  Changes in reading  Word-retrieval problems  Hyperverbal speech  Difficulty following conversations for extended periods of time |
| Do you have any eating or swallowing difficulties? If yes, please describe: |

**IMPACT ON FUNCTIONING**

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| Participation restrictions (rate all that apply):  Activities of daily living (e.g. daily hygiene, emails, etc):  Household tasks (e.g. cleaning, cooking, laundry, etc):  Interpersonal interactions:  Education:  Employment:  Community:  Other (please specify): | | MILD  MODERATE  SEVERE  MILD  MODERATE  SEVERE  MILD  MODERATE  SEVERE  MILD  MODERATE  SEVERE  MILD  MODERATE  SEVERE  MILD  MODERATE  SEVERE  MILD  MODERATE  SEVERE |
| What are your major complains at the time of this evaluation? | | |
| Person completing this form: | Relationship to client: | |
| Signature: | Date: | |