**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/TemporomandibularOLFACTORY PROBLEMS:[ ]  Diminishing taste and smellVESTIBULAR / BALANCE PROBLEMS:[ ]  Dizziness [ ]  VertigoAUDITORY DISTURBANCE:[ ]  Tinnitus [ ]  Hearing Loss [ ]  Noise SensitivityVISUAL 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: |