Central Florida Speech & Hearing Center

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863-686-3189
Fax: 863-682-1348

3020 Lakeland Highlands Road - Lakeland, FL 33803

Adult Speech Case History Form

Patients Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____ Email: _____

_____

Phone: _____ Alternate phone: _____

Name/Relationship of person completing form: _____

Referring Physician : _____ Family Physician: _____

Insurance Information

Company: _____ Insured's Name: _____

Policy # _____ Group # _____ Phone # _____

Primary language: _____

Reason for referral/Visit: _____

What information do you hope to obtain from this evaluation? _____

_____

Speech-Language History

Please describe your speech/language difficulties: _____

_____

When did you first notice the problem(s)? _____

_____

Did the problem begin suddenly or gradually? _____

If Known, what is the cause of the speech/language diffuculties ? _____

_____

Has the speech/language problem changed since first diagnosed? __ Yes __ No

If yes, explain: _____

Please describe how your communication problems are impacting your daily life: _____

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Have you ever been evaluated by or had treatment with a Speech Language Pathologist?

Yes No When? _____ Reason/Results? _____

Medical History

How would you rate your current general health? Excellent Average Poor

Have you ever been hospitalized? Yes No

Explain: _____

Have you ever had surgery? Yes No

Explain: _____

Previous Medical History (check all that apply)

__ Headaches __ Dizziness __ Encephalitis __ Hearing Loss

__ Pneumonia __ Allergies __ Hypertension __ Seizures

__ PEG tube __ Diabetes __ Cardiac Issues __ Reflux Disease

__ Anemia __ Asthma __ Bronchitis __ Cancer/Tumors

__ Dizziness __ Hearing Aid __ Glasses __ Chronic Laryngitis

__ Meningitis __ Hoarseness __ Tonsillectomy __ Laryngectomy

__ Adenoidectomy __ Colds __ Paralysis __ HIV

__ Hepatitis __ Pacemaker __ Dental Problems __ Sleeping Difficulties

__ Balance Problems __ Respiratory/Lung Problems __ Learning Disabilities

__ Visual Problems __ Thyroid Problems __ CVA (stroke) (date_____)

__ Head injury (date_____) __ Depression/ Emotional Disorder

__ Coordination Problems __ Incoordination/weakness of face or tongue muscles

Other: _____

Do you have any difficulty eating or drinking? Yes No

Do you use any of the following assistance devices?

__ Wheelchair __ Walker __ Cane __ Other _____

Have you seen any other specialists (physicians, psychologist, audiologist, neurologist, etc...)? Yes No

If yes, who? _____

What were their conclusions or suggestions? _____

Are you right or left handed? __ Right __ Left

Do you __ Smoke __ Consume Alcohol

Current medications (prescription and nonprescription):

Medication	Reason taking/Prescribed

Any other health problems not mentioned above?

_____

_____

Family History

Spouse's/Partner's Name: _____

Children	Age

Do you have any family history of speech/language/hearing problems? Yes No

Explain: _____

Educational & Work & Social History

Highest level of education (grade or degree) completed: _____

Have you ever had difficulty with the following areas prior to your illness or accident? (check all that apply)

__ Understanding __ Reading __ Speaking __ Writing
__ Math __ Attention __ Memory __ Problem Solving

Currently Employed? Yes No

Occupation: _____

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Employer: _____

Are you currently driving? Yes No
Have you had to stop doing any of your previous activities? Yes No
If yes, what and why? _____

Please list any specific hobbies, interest, or social activities: _____
_____

Do you have any family/friends that can (or do) assist you throughout the day? Yes No

Please provide additional information that might be helpful in the evaluation or treatment process:
_____
_____
_____

The United Way of Central Florida has asked us to collect ethnicity data on all of our patients. Please check one of the following categories as it pertains to either you, if you are the patient, or your child, if they are the patient. We sincerely appreciate your help with this.

- ❑ White
- ❑ Black
- ❑ Hispanic
- ❑ Asian
- ❑ Native American
- ❑ Multi-Racial
- ❑ Race Unknown

How did you hear about us?

____ Mail ____ Newspaper ____ Promotional Call ____ Radio ____ Insurance ____ Yellow Pages

____ Sponsored Event ____ Health/Senior Fair ____ Web site ____ Employer

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MEDICAL RELEASE

Patient Name _____ Date_____

I ,_____, hereby give Central Florida Speech and Hearing Center (CFSHC) permission to share relevant clinical information regarding (patient's name) _____with the professionals listed below. I also authorize CFSHC to release and/or share any information requested by my insurance company.

Relationship to Patient_____ Signature_____

We would like to send a copy of the evaluation report to the patient's:

Referring Physician_____(Name)

Telephone_____

Address: _____
Street City State Zip Code

Is there anyone else you would like to receive a copy of the report?

Name_____

Address_____
Street City State Zip Code

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