



19465 Deerfield Avenue, Suite 201
Lansdowne, Virginia 20176
703-858-7620 VOICE & TTY
703-858-7657 FAX

ADULT CASE HISTORY FORM
Speech-Language Pathology

Please fill out this form as completely as possible. The information will help us understand your present communication problem(s) and will aid us in planning appropriate testing procedures.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

***PLEASE NOTE: AFTER COMPLETION, PLEASE RETURN THIS FORM, ALONG WITH ANY OTHER PERTINENT MEDICAL REPORTS (e.g. Hospital discharge summaries, Neurological reports) TO THE CENTER AT LEAST (1) WEEK BEFORE THE SCHEDULED EVALUATION**

(Please Print or Type)

Client's Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

E-Mail Address: _____

Date of Birth: _____ Sex: ____ Age: ____ SSN: _____

Marital Status: **S M D W**

Ethnicity: **African American – Asian – Caucasian – Hispanic/Latino**
Other _____

Employer: _____ Employer Phone: _____

Name of Spouse: _____

Spouse Employer: _____ Employer Phone: _____

Combined Income *(Please check one)*

Less than \$12,000 ___	\$30,000-\$50,000 ___	\$90,000-\$120,000 ___
\$12,000-\$20,000 ___	\$50,000-\$70,000 ___	over \$120,000 ___
\$20,000-\$30,000 ___	\$70,000-\$90,000 ___	

How did you hear about us? *(Please circle one)*

Word of Mouth **Phone book/yellow pages** **Internet** **Physician**
Other _____

If Physician, please list name: _____

Reason for Referral: _____

Briefly Describe Problem: _____

**If you do not want to receive information about new services, fundraising events
Or other BRSB news, please check here**

SPEECH AND HEARING HISTORY

Please mark if you have a history of difficulty with any of the following:

<u>Symptoms</u>	<u>Never</u>	<u>Rarely</u>	<u>Frequently</u>	<u>Date of Last Incidence</u>
Swallowing (coughing/choking/pain)				
Stuttered speech				
Expressing Thoughts				
Orientation				
Judgment				
Problem Solving				
Maintaining Topic of Conversation				
Memory				
Focusing/Attending				
Following Directions (processing information)				
Reading/Writing				
Slurred speech				
Word Finding				

What do you expect to get out of therapy? *(Please be specific)*: _____

How do others react toward the problem: _____

Is there a family history of this problem? Please explain: _____

Have you had previous speech therapy for this current problem? Please explain: _____

Has this problem improved/deteriorated since the onset? Please explain: _____

HEALTH HISTORY

Please mark any of the following disorders that you have experienced.

Disorders	Never	Rarely	Frequently	Date of onset	Date of last Incidence
Allergies/ Sinusitis					
Facial Numbness					
Stroke/TIA's					
Hoarseness					
Illness/High Fevers					
Heart Disease/ Atrial Fibrillations					
Head Trauma					
Reflux/Heartburn					
Hypertension					
COPD					
Pneumonia					
Injury/Falls					
Surgery					

If you have had treatment for any of the above disorders, please describe: _____

Were you hospitalized for this condition? (Include Dates and Names of Hospitals.) _____

Please list all medications you are currently taking and the reason for which they have been prescribed along with any side effects:

MEDICATION	REASON taking MEDICATION	SIDE EFFECTS (Please specify)

Name of Insurance and Address: _____

Policy #: _____ Named Insured: _____

Medicare # _____ Medicaid #: _____

Person responsible for payment: _____

Signature of Responsible Party: _____

Date: _____

Please list any persons (other than yourself) you wish a copy of this evaluation report be sent.

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

Name of person completing this form: _____

Relationship to Client: _____ Phone: _____



Blue Ridge Speech and Hearing Center
19465 Deerfield Avenue, Suite 201
Lansdowne, Virginia 20176
703-858-7620 FAX 703-858-7657

Patient Name: First Middle Last

Permanent Address: (no PO BOX): Street City State Zip

Mailing Address: (if different from above) Street City State Zip

Home Phone: Work Phone: Cell:
Date of Birth: Sex: Male Female
Marital Status: Single Married Divorced Widowed

Patient Employment Information (if patient is a minor, parent complete):

Employee / Father Place of Employment Name City, State Occupation Telephone

Employee / Mother Place of Employment Name City, State Occupation Telephone

Who referred you to this office? Nearest Relative: (not at same address) Name Telephone

Private Pay Insurance

Primary Insurance Name: Address City State Zip

Subscriber's Name: ID #:
Group Name: Group #:

Secondary Insurance Name: Address City State Zip

Subscriber's Name: ID #:
Group Name: Group #:

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process these claims. I also authorize payment of medical benefits to the provider for services described.

Signed Date

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