THE UNIVERSITY OF MAINE

Speech Therapy Telepractice and Technology

Graduate Student Training Program
Department of Communication Sciences and Disorders

Adult Case History Form

Confidentiality Statement

In order to provide the optimum level of service, appropriate to your needs and wishes, certain background information is very helpful. The information requested will assist us in understanding and developing a plan that best suits your needs. Many factors may impact on the hearing, understanding, and use of speech. The information you provide us will help us understand your concerns and assist us in addressing your needs with you.

If possible, complete this information form and return it to us a week before the date of your first appointment. Thank you for your time and cooperation.

Date: _____

General Information

Name of Client: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Email Address: _____

Employer/School: _____

Marital Status: Single ____ Widowed/Divorced ____ Married ____ Spouse's Name: _____

Children (include name, gender and ages):_____

_____

_____

Name of person completing questionnaire if other than the client named above: _____

Referred by: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Person/Agency paying for service: _____

Medical History

Describe the events that led to your current medical condition.

Status of vision and hearing:_____

Condition of oral structures (i.e., teeth, tongue, etc.): _____

Oral/motor impairments (i.e., slurred speech, weakness of lips, tongue, jaw, etc.): _____

_____

Special concerns regarding physical condition: _____

_____

Describe any major surgeries, operations, or hospitalizations that you have experienced in the past (include approximate dates).

Check which of the following illnesses and conditions you have experienced:

Adenoidectomy	_____	Allergies	_____	Asthma	_____	Chicken Pox	_____
Convulsions	_____	Dizziness	_____	Draining Ear	_____	Ear Infections	_____
Encephalitis	_____	German Measles	_____	Headaches	_____	Hearing Loss	_____
High Fever	_____	Influenza	_____	Mastoiditis	_____	Noise Exposure	_____
Otosclerosis	_____	Pneumonia	_____	Seizures	_____	Sinusitis	_____
Tinnitus	_____	Stroke	_____	Tonsillectomy	_____	Head Injury	_____

Other: _____

Do you have any eating or swallowing difficulties? If so, please describe.

List all medications you are currently taking.

Are you having any negative reactions to these medications? If yes, please describe.

Describe any cognitive and/or language difficulties you are currently experiencing.

What do you believe may have caused these difficulties?

How does your communication difficulty affect your daily activities at home, with friends, at work, in the community?

Developmental History

Did you reach all of your developmental milestones on time?

Do you have a history of learning disability, reading or writing problems?

Educational and Vocational History

What is the last grade you completed in school?

Describe your employment history. Are you currently employed?

Family History

Describe your family members and where they live.

Are there any family members who experience communication difficulties? If yes, tell us your relation to the family member and describe the nature of the difficulties.

What languages are spoken at home? Include what languages you speak and which is your primary language.

Hobbies and Interests

What are your hobbies and/or special interests?

What organizations do you participate in (church, community, etc.)?

Computer Skills

1. Describe your computer and any other digital devices that you know how to operate.

2. Does your computer have video and audio connections? Yes No

3. Do you have Internet access? Yes No

4. How many years have you used computers? _____

5. How often does your child use computers, smart phones or other digital devices?

   Daily Weekly Monthly

6. Rate your child's knowledge and experience of using computers.

   Beginner Average Advanced

Why did you decide to request speech therapy telepractice services? What do you hope will result?

How did you hear about us?

Provide any additional information that might be helpful in the evaluation or therapy process.

Person completing this form: _____

Signature: _____ Date: _____

If you have any questions regarding the completion of this information form, call our office at 207.581.2006.

Return this form to:

lynk@maine.edu

or

Madelyn E. and Albert D. Conley Speech, Language and Hearing Center
Department of Communication Sciences and Disorders
University of Maine
5724 Dunn Hall, Room 344
Orono, ME 04469-5724