Speech-Language-Hearing Clinic
516 High Street, MS 9171
Bellingham, WA 98225
Ph: 360.650.3881 Fax: 360.650.4334

ADULT CASE HISTORY INTAKE FORM

Please complete all sections of this form.

CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Preferred Name (if different): _____ Spouse/Partner's Name: _____

Referred to this clinic by: _____

Occupation: _____ Work Phone: _____

If retired, from what: _____ Home Phone: _____

Daytime Phone: _____ Cell Phone: _____

Email address (used only for scheduling): _____

Gender: _____ Preferred pronoun: _____

Communication History

What are your concerns for coming to the clinic? Feel free to share specific goals or questions you might have.

Describe your current speech, language, cognition (memory, thinking, reasoning), voice, respiratory and/or swallowing concerns.

When did the concerns start? Has it improved or worsened?

Please describe situations when it is better/worse?

Have you seen any other speech-language specialist(s)? Who and when? What were their conclusions or suggestions?

What have you done to try to improve your communication or current difficulty?

How do you feel this situation has affected your social life, career, education, etc.?

Have you seen any other specialist (physical/occupational therapists, surgeons, physicians, psychologists, neurologists, etc.) concerning your problem? If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

Are there any speech, language, voice, hearing, or respiratory concerns in your family? If yes, please describe.

Social History

Who lives in your home?

Children (names, ages):

Who are your communication partners?

What languages do you speak? If more than one, which is your primary language?

What was the highest grade, diploma or degree completed? Please list any other certifications.

What activities, hobbies, or groups are you involved in?

Describe a typical day. Include wake time, time(s) you eat, rest, work, read, exercise, and/or enjoy recreation.

Medical History

Please check the following if they apply:

COVID-19	_____	Memory/concentration/attention concerns	_____		
Allergies	_____	GERD/Reflux	_____	Laryngopharyngeal reflux	_____
Noise exposure	_____	Dizziness	_____	Voice concerns	_____
Blood pressure: High	_____	Low	_____	Arrhythmia	_____
Ear infections	_____	Encephalitis	_____	Depression	_____
Seizures	_____	High fever	_____	Head Injury	_____
Otosclerosis	_____	Meningitis	_____	Stroke	_____
Sinusitis	_____	Measles/Mumps	_____	Concussion	_____
Tinnitus	_____	Mastoiditis	_____	Headaches	_____
Pneumonia	_____	Chronic cough	_____	Anxiety	_____
Asthma	_____	Difficulty breathing	____	Lung disease	_____
Hearing Loss	_____	Last hearing test?	_____		

Other medical history:

Is there a history of?

	Yes	No	
Smoking	___	___	How much per day? _____
Drinking	___	___	How much per day? _____

Describe any medical concerns you are <u>currently</u> experiencing.

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

List all medications and the purpose for each. <u>Please use the back if you need more room</u>.

Medication	**Dosage**	**Purpose**

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

Describe any major surgeries or hospitalizations (including dates).

Describe any major accidents.

In the space below, please provide any additional information that might be helpful in the evaluation or treatment process.

Person Completing Form (print name): _____

Relationship to Client: _____

Signature: _____ Date: _____

For Office Use Only: Received by _____ Date received: _____