CASE HISTORY/INTAKE FORM

Please fill out this form to the best of your ability and return prior to your evaluation appointment. This information will give us a better understanding of your history and help out with the evaluation process. All information is strictly confidential.

Today's Date: _____

Person completing this form: _____

Description of problem/concern: _____

_____

_____

What do you think caused the above difficulties? _____

_____

When did you first notice the problem? _____

Has the problem changed (worsened/resolved) since it was first noticed? Explain. ___

_____

_____

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

_____

GENERAL INFORMATION

Client Name: _____ Birthdate: _____ Sex: ❑ M ❑ F

Address: _____ Email: _____

Emergency Contact Information (name/contact number): _____

_____

Language(s) spoken: _____

**Referred by: _____

MEDICAL HISTORY

Doctor's name/Contact info: _____

Dentist/Orthodontist name/Contact info: _____

Have you been seen by any specialists? ❑ Yes ❑ No

If yes; please list names, type of specialist, contact information, date seen, and results

_____

_____

_____

_____

_____

Please mark if you have a diagnosis of any of the following conditions *(list dates or additional information if applicable):*

❑ Food Allergies: _____ ❑ Special Dietary Restrictions: _____

❑ Other Allergies: _____

❑ Ear Infections: _____ ❑ ADD/ADHD

❑ Frequent Headaches: _____ ❑ Seizures: _____

❑ Asthma/breathing difficulties ❑ Autism Spectrum Disorder

❑ Anxiety ❑ Depression ❑ Other: _____

❑ Sleeping difficulties (if so, please explain): _____

❑ Vision difficulties (if so, please specify): _____

❑ Hearing loss/difficulties (if so, please specify): _____

List any medications you take regularly: _____

_____

_____

Have you had any surgeries or been hospitalized for any reason? *If yes, please list and provide approximate dates.* _____

_____

_____

_____

_____

FAMILY/SOCIAL HISTORY

Please list any other individuals living with you (please specify names, ages, relationship): _____

_____

List all family members: (please include parents, siblings, and/or children):

N*ame* *Age* *Sex* *Speech/Hearing Difficulties (if applicable)*

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please select your current marital status:

❑ Single ❑ Married ❑ Separated/Divorced ❑ Widowed

Spouse's name (if applicable): _____

Describe your current or past occupation/employer: _____

_____

_____

Highest grade, diploma, or degree earned: _____

SPEECH-LANGUAGE HISTORY

Have you ever received speech therapy services? ❑ Yes ❑ No

If yes; where and when? _____

What were you working on? _____

_____

What were the recommendations? _____

_____

How would you describe your speech? _____

_____

Do you have difficulty expressing your wants and needs? If yes, please explain. _____

_____

_____

Do others find you difficult to understand? If yes, please explain. _____

_____

_____

Do you find it hard to understand others? If yes, please explain. _____

_____

_____

Do you have short-term and/or long-term memory difficulties? If yes, please explain. _____

_____

_____

Do you have difficulty with word finding (i.e. remember the names of objects and/or people)? If yes, please explain. _____

_____

_____

Do you have difficulty with reading or writing? If yes, please explain. _____

_____

_____

Please mark if you require assistance with any of these daily living activities:

❑ Dressing	❑ Managing finances	❑ Cleaning/house keeping
❑ Toileting	❑ Telling time	❑ Showering/person hygiene
❑ Cooking	❑ Keeping track of appointments	❑ Moving/walking
❑ Eating	❑ Making phone calls	❑ Laundry
❑ Running errands	❑ Ordering food through a drive-thru	❑ Driving/transportation

❑ Other: _____

OTHER INFORMATION

What kinds of hobbies/activities do you enjoy? _____

_____

_____

What is your preferred learning style?

❑ Written instruction ❑ Verbal instruction ❑ Demonstration ❑ Hands-on

❑ Other: _____

What would you like to work on/address in speech therapy? _____

_____

Please provide any additional information that might be helpful in completing your evaluation.

_____

_____

_____

_____