

Adult Case History

Name:	Birth date:
Address:	Email:
	Phone Number: () -
Occupation:	Level of Education:
Who do you live with:	
Date of Onset of problem:	Physician:

CONCERNS: Describe the speech, language and/or swallowing problems briefly.

DIAGNOSIS:
Previous therapy/where
Previous Modified Barium Swallow Study

Circle all which apply

Allergies	Asthma	Pneumonia	Laryngitis	Thyroid problems
Coughing during meals	Swallowing problems	Hearing problems	Vision Problems	Hoarseness
High Pitch voice	Low Pitch voice	Loud voice	Soft voice	Slow rate of speech
Vocal nodules	Stuttering	Word finding problems	Memory problems	Trouble being understood
Trouble following directions	Reading problems	Writing problems	Reasoning problems	Confusion
Trouble organizing thoughts	Trouble forming sentences	Trouble following directions	Trouble paying attention	