Center for Speech and Language Disorders

Therapy that makes a difference

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Chicago site: 820 North Orleans Street , Ste 217 ,Chicago, IL 60654
Phone: 630-652-0200 ext 201

Adult Medical Case History

Date___________________ Sex: ☐ Male ☐ Female

Name: ____ Marital Status ________________________

Address:__________________________________City:________________________ St.______ Zip_____________

DOB: _________________ Age: _____ H. Ph : _____________________ W.Ph: ______________________

Cell:____ Email:____________________________________

Please list all people who live with you:

____ ____

____ ____

Does anyone in the family have developmental delays, speech problems, hearing problems or special needs?
☐ Yes ☐ No

Medical Insurance:_____________________________ Id #____________________________________

Primary policy holder:___________________________ Group No. ______________________________

Briefly explain the communication difficulties you are currently experiencing: _________________________________

____

____

Have you previously had a speech evaluation(s) or therapy? ☐ Yes ☐ No

If yes, please state when, where and reason: ____

____

____

MEDICAL HISTORY

Please list any medical conditions for which you have been or are currently being treated:

____

____

____

Medications presently taking and reason: ____

____

Please list all:

HOSPITALIZATIONS/DATE	REASON	LOCATION

Are your immunizations current? ☐ Yes ☐ No

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over

Physician Information:

Name of Physician: ____

Address: ____________________ City __________________ St.____ Zip________

Phone No:______________________________ Fax:____________________________

Speech-language Pathologist:____

OTHER INFORMATION

Occupation: ____

Employer:____

How long at this occupation: ______________________________________

Last grade competed: ______________________ Currently in school? ☐ Yes ☐ No

If yes: ☐ Full time ☐ Part time Where?______________________________

______________________________ ______________________________

Name of person completing form (if other than client) Relationship to client

*Please mail/fax this face sheet along with any relevant evaluation reports (i.e., speech-language, neurological and/or psychological evaluations) you would like to share with your therapist ***the week before your evaluation if possible.***