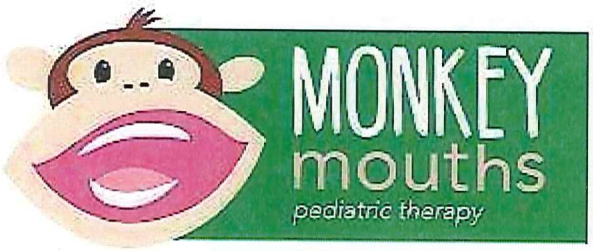

Adult Case History Form

Date: _____

Patient Name: _____

Patient Date of Birth: _____ Age: _____

Home Phone: _____

Work Phone: _____

Email: _____

Emergency Contact: _____

Patient Address: _____

_____

Primary Care Physician: _____

Name of person completing this form: _____

Relationship to Patient: _____

STATEMENT OF THE PROBLEM

Reason for referral:

_____

_____

_____

Describe the problem:

_____

_____

_____

What skills do you hope to gain if therapy is warranted?

_____

MEDICAL HISTORY

Is there any history of medical concerns? Yes No

Please describe any medical concerns, injuries, illnesses, or surgeries:

_____

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

_____

SPEECH INTELLIGIBILITY:

Is your speech understood by others? Yes No

Have you been evaluated by other professionals (i.e. dentist, occupational therapist, physical therapist, psychology, etc)?
Yes No If yes, please explain:

_____

_____

FEEDING

Do you have any food allergies or sensitivities that you are aware of? Yes No
If yes, which foods? _____

Are there any additional diet restrictions due to personal, cultural, or religious reasons we should be respectful of? (i.e. Vegetarian, Vegan, Gluten free, No pork) Yes No

_____

_____

Do you have a latex allergy? Yes No

Do you have to make modifications to foods during meals/snacks? Yes No
If yes, please circle which ones:

Thickening liquids Cutting food into smaller bites
Alternating food/drink Multiple swallows

INTEREST INVENTORY
What are your interests or hobbies?

_____

_____

Is there anything else you wish to add that would help insure a positive testing experience for you?

_____

_____

_____

Thank you very much for your help and for the information provided here.