License # SA 1280

Case History- Adult

Patient's Name:________________________ Date:__________________________

Address: ____zip Code:_______________

Telephone: ____________ cell:________________email________________________

Occupation:_________________________Employer:___________________________

Business Phone:_____________Business Address:____________________________

If Retired, Former occupation:____

Spouse's Name: _________________Spouse's occupations_____________________

Referred to this office by:____

Reason for referral or patient's concerns: ____________________________________

Physicians Seen on regular basis:

Name: __________________________Phone:__________________________________
Address:________________________Area of Specialization:____________________

Name:___________________________Phone:__________________________________
Address:________________________Area of Specialization:____________________

Name:___________________________Phone:__________________________________
Address:________________________Area of Specialization:____________________

11099 Lynwood Palm Way, Palm Beach Gardens, FL 33412
rbestspeechtherapy.com **(954) 629-1521** **robin@ rbestspeechtherapy.com**

Medication Taken on a regular Basis:

Reason for Medication:____
Medication:____________________Dose:______________Times/Day________

Reason for Medication:____
Medication:___________________Dose:_____________Times/Day__________

Reason for Medication:____
Medication:____________________ Dose:___________ Times/Day__________

Reason for Medication:____
Medication:____________________ Dose:___________Times/Day___________

Reason for Medication:____
Medication:____________________Dose:____________Times/Day__________

Primary Diagnosis:____
Date Diagnosed:___________Physician who Diagnosed:____________________
Secondary Diagnosis:____

Medical History

1. Other illnesses during recent months?_________________________________
2. Are there any problems associated with eating?__________________________
3. Are there any problems with sleeping?________________________________
4. Hospitalizations/Surgery
Date:_____________________Reason:________________________________
Date:_____________________Reason:________________________________
Date:_____________________Reason:________________________________
Date:_____________________Reason:________________________________

Health/Medical Information

1. **Vision**:

Have you ever felt that you had difficulty seeing?______________________________

Do you have difficulty seeing while wearing glasses or contact lenses?____________

Do any of the following apply in your situation?

Rub eyes frequently____________________ Hold objects close to eyes?__________

Squint________________________________Red or watery eyes?________________

Frown often of tilt head to one side_______ Eyes hurt________________________

Have you ever had your eyes checked or examined?____________________________

If so, by whom?____

Date of last eye exam:____

Do you wear glasses and/or contact lenses?_________________________________

Do you feel your vision has been corrected adequately?________________________

Have you received treatments or vision intervention?__________________________

(dates)_____________________________

2. **Hearing**:

Have you ever felt that you had difficulty hearing?_____________________________

Check any that apply:

Frequent ear infections or colds_______________Fluid draining for ears___________

pull or poke at ears___________Do not respond to voice or sound________________

Have you ever had your hearing or ears checked or examined?__________________

If so, by whom? (explain):____

Do you wear hearing aids?____

Were hearing aids every recommended?_______________________________________

3. **Doctor**:

When was the last time you saw a doctor?____________________________________

Why?____

Do you receive medical care regularly?_______________________________________

4. **Any pertinent medical history regarding previous illnesses:**

____

____

Accidents?____________________________Seizures?_____________________________

Other:____

____

5. **Dental Services:**

Have you had your teeth checked recently?__________________________

Dentist:_____________________Address:_____________________ phone:_____________

Do you have bridge work?____

6. Have you received extensive tests, ie:;

MRI, CAT, SCA, BERA,

List tests Dates Results

____

____

Have you ever been tested or treated by anyone else, not mentioned previously (i.e., a psychologist, psychiatrist, physical therapist, speech therapist, neurologist, educational specialist, etc.) Explain:

____

____

Personal Information

Please list all interests and hobbies:

____

____

Any additional comments that may help me treat you more effectively:

____

____

Looking ahead, what are your future expectations:

____

____

____

______________________________ ______________________________

Robin Best, M.A., C.C.C., P.A. Date

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