In Plain English, llc

Adult Case History Form

Please fill out this form as completely as possible. If you need more space, attach another page, or write on the back. Call 804 539 8843 if you have additional questions regarding these forms.

Today's Date

Name | Birthdate | Age | Gender

Home Phone | Cell Phone | Work Phone

Preferred Method of Contact | Email Address

Address

City, State, Zip

Spouse or Responsible Party | Age

Reason for Referral | Referring Person

Birth History

Do you know of any difficulties during pregnancy, labor, or delivery?

What was your mother's age and health at your birth?

Did you have any of the following at birth? (check all that apply)

- ☐ Jaundice
- ☐ Cyanosis
- ☐ Rh incompatibility factors

Medical History Please mark if and when you have had any of the following:

- ☐ Seizures
- ☐ Whooping cough
- ☐ Meningitis
- ☐ Chronic Colds
- ☐ Chronic Laryngitis
- ☐ High Fevers
- ☐ Diphtheria
- ☐ Encephalitis
- ☐ Ear Infections
- ☐ Diabetes
- ☐ Measles
- ☐ Mumps
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Thyroid
- ☐ Asthma
- ☐ Head Injuries
- ☐ Chicken Pox
- ☐ Tonsillitis
- ☐ Sinusitis
- ☐ Heart Trouble
- ☐ Allergies

For items marked above, give the relevant details (e.g., frequency and/or severity of episodes):

____

____

Are immunizations current? ☐ Y ☐ N

Current general health? ____

____

Any other serious or recurrent illnesses? (indicate date) ______________________

____

Any operations? (indicate date) ______________________________________

____

Any accidents? (indicate date) _______________________________________

____

Hearing difficulties? ☐ Y ☐ N If so, aided? ☐ Y ☐ N

Vision problems? ☐ Y ☐ N If so, treatment? ____________________________

Dental problems? ☐ Y ☐ N If so, treatment? ____________________________

Other: ____

Dominant Hand: ☐ Left ☐ Right

____

Personal Primary Physician | Date of last visit

____

Address or location

____

Ongoing Medical Care (Describe)

____

Physician's Name | City

Current Medications	Dosage	Physician

Chronic Health Problems (Asthma, Congenital Defects, etc.) ____________________

Handicaps (Describe, if any) ____

____

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Family

Children

Name ____________ Age ____ Name ____________ Age ____

Name ____________ Age ____ Name ____________ Age ____

Any speech or hearing problems in the family? ☐ Y ☐ N

Describe: ____________

Speech and Language

Do you know of any concerns regarding early speech and language development? ☐ Y ☐ N

Describe: ____________

Other language(s) spoken in the home: ____________

Have you ever had difficulty understanding or expressing yourself? ☐ Y ☐ N

Describe: ____________

What are your communication needs in social settings? ____________

What difficulty do you have meeting your communication needs? ____________

Educational History

Schools attended	Diplomas or degrees

Future educational plans: ____________

Were you or are you satisfied with your academic performance? ☐ Y ☐ N

If no, why not? ____________

How did or does your communication difficulty affect your performance in school? ____________

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Vocational History

How have communication difficulties affected the types of jobs you have held? ______________________________

____

Describe your current job setting and your communication needs: ______________________________

____

How do communication problems affect your current job? ______________________________

____

Does your communication difficulty affect your future job plans? ☐ Y ☐ N

Describe: ____

____

General information

Hobbies: ____

____

Social and/or civic groups to which you belong: ______________________________

____

Other information you would like us to know: ______________________________

____

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Please include relevant reports and information from other agencies.