



Access Rehab Centers

A Waterbury Hospital & Easterseals Partnership in Physical Rehabilitation

Thank you, for choosing Access Rehab Centers. We kindly request that you fill out all the necessary information for our therapists to complete a comprehensive evaluation. Please mail this packet back prior to the evaluation, if possible, so it can be reviewed.

SPEECH ADULT - CASE HISTORY FORM

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip: _____

Occupation: _____ Business Phone: _____

Employer: _____

Referred by: _____ Phone: _____

Address: _____

Family Physician: _____ Phone: _____

Address: _____

Are you: Single Widowed Divorced Married - Spouse's Name: _____

Children: (include their name, gender and age)

Who lives in the home?

What language(s) do you speak? Which is your dominant language? _____

What was the highest grade, diploma or degree you earned? _____

GENERAL INFORMATION

Describe your speech-language problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed? How? Yes No

Have you seen any other speech-language specialists? Yes No

If Yes, When and for how long? _____

What were their conclusions or suggestions?

Have you received any speech therapy while homebound? Yes No

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc)?

Yes No

If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

Are there any other speech, language or hearing problems in your family? Yes No

If yes, please describe:

MEDICAL HISTORY

Provide the approximate ages at which YOU suffered the following illnesses and/or conditions:

Allergies	Asthma	Colds
Dizziness	Draining Ear	Ear Infections
Encephalitis	Headaches	Hearing Loss
High Fever	Influenza	Mastoiditis
Meningitis	Noise Exposure	Otosclerosis
Pneumonia	Seizures	Sinusitis
Tinnitus	Other	

Do you have any eating or swallowing difficulties? Yes No

If yes, please describe:

List all medications you are taking.

Are you having any negative reactions to these medication? Yes No

If yes, please describe:

Describe any major surgeries, operations or hospitalizations and when they occurred.

Describe any major accidents and when they occurred.
