speechcare
Speech pathologists who care

ADULT CASE HISTORY FORM

Name: _____ Date of Birth:_____ Age:___

Mobile phone: _____ Home phone: _____ Work phone: _____

Home address: _____

Postal address: _____

Email address:_____@_____

Carer/Next of Kin: _____

Do you have private health insurance? Yes ☐ No ☐ Name of Fund: _____

Medical Practitioner (GP/Specialist): _____

Reason for referral:

☐ Stuttering ☐ Voice ☐ Accent Reduction

☐ Speaking in Public ☐ Adult Literacy ☐ Swallowing

☐ Difficulties with language *(ie after Stroke/Brain Injury)*

☐ Speech difficulties *(including slurred speech)*

☐ Other (*please specify*): _____

Do you speak a language other than English at home? ☐ Yes ☐ No

If yes please specify: _____

How did you hear about us?

☐ Google/Website ☐ Yellow pages ☐ Walk in ☐ Family/ Friends ☐ Other _____

next page/

Medical History - ***Please provide copies of relevant medical reports.***

Are there any diagnosed illnesses/disorders? *If yes please provide details* ☐ Yes ☐ No

_____

Have you recently been hospitalised? *If yes please provide details* ☐ Yes ☐ No

_____

Have you had any recent operations? *If yes please provide details* ☐ Yes ☐ No

_____

_____

Is there a history in your family of:

☐ Heart disease ☐ Blood pressure ☐ Asthma ☐ Stroke

☐ Diabetes ☐ Hearing loss ☐ Allergies *(eg hay fever)*

☐ Cognitive changes *(e.g. Dementia)* ☐ Neurological conditions *(e.g. Parkinson's)*

☐ Digestive conditions *(e.g. reflux, ulcers)*

☐ Other - *please provide details*: _____

Previous Intervention

Have you ever been assessed by a Speech Pathologist or received speech therapy? ☐ Yes ☐ No

If yes please provide details:_____

Have you been assessed by another allied health professional (ie Psychologist, Physiotherapist, OT)?

☐ Yes ☐ No *If yes please provide details*:_____

Consent to Treatment – Client Information

I understand that if I have any questions or concerns regarding my treatment, I should discuss them with the Speech Pathologist before signing this consent.

I understand that at times, it is important for my clinical information to be shared with other relevant Professionals, such as a GP, a referring Specialist or an Allied Health Professional.

I understand that a minimum of 24 hours notice is required for appointment changes or cancellations and that those appointments cancelled or changed with less than 24 hours notice may incur a $40.00 fee.

I consent to treatment and I consent to the release of my clinical information to other relevant Professionals if required.

The information I have provided is correct and complete.

Signed: _____ **Date:** _____

Thank you for taking the time to complete this form.