speechcare
speech pathologists who care

ADULT CASE HISTORY FORM

Name: ______________________________ Date of Birth: ____________Age: ________

Preferred name (if different): ____

Outline specific identifiers (eg. pronouns) where preferred: ______________________________

Preferred phone number: ____

Alternate phone number: ____

Home address: ____

Postal address (leave blank if same): ______________________________________

Email address: ______________________@______________________

Carer/ Next of Kin/ Emergency Contact (please circle those that apply)

Name: ____

Contact details: ____

Do you have private health insurance? Yes ☐ No ☐

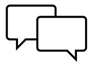
Name of Fund: ______________________________

Medical Practitioner/referring doctor (GP/Specialist): ______________________________

Phone Number: ______________________________

Address: ______________________________

Aboriginal or Torres Strait Islander? Yes ☐ No ☐



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

If yes, please specify: ______________________________

How did you hear about us?

☐ Google/Website ☐ GP/Specialist Referral ☐ Family/ Friends ☐ Other____________

Referral Information

Reason for referral:

☐ Stuttering ☐ Voice ☐ Accent Reduction

☐ Speaking in Public ☐ Adult Literacy ☐ Swallowing /Mealtimes

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

☐ Speech difficulties *(including slurred speech)*

☐ Other (*please specify*): ______________________________

Notes:

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

☐ Digestive conditions *(eg. reflux, ulcers)*

☐ Other conditions related to speech, language, literacy, social communication- *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 24hours notice is required for appointment changes or cancellations and that those appointments cancelled or changed with less than 24hours notice may incur a $50.00 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.

Name: ______________________________ **Signed:** ______________________________

Date: ____________________

Thank you for taking the time to complete this form.

Clinician Notes:

Assessments, Intervention Plan (frequency/duration), further information required