



## Adult Case History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Home#: \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Email Address: \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ \*\* Please provide a copy of card front/back

ID Number \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### History

Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Highest Degree Earned: \_\_\_\_\_ Date: \_\_\_\_\_

Is English your primary language? \_\_\_\_\_ Yes \_\_\_\_\_ No

If not, what is your primary language? \_\_\_\_\_

Is there any history of speech, language or hearing difficulties in your family? If so please list:

---

---

---



**Medical History**

General Health: \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor

Do you have any medical diagnosis? If so, specify\_\_\_\_\_

\_\_\_\_\_

List medications taken on a regular basis:\_\_\_\_\_

\_\_\_\_\_

Are you sensitive to latex? \_\_\_ Yes \_\_\_ No

Please check all that apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies                                 | <input type="checkbox"/> Dental Problems               |
| <input type="checkbox"/> Frequent Laryngitis/Hoarseness            | <input type="checkbox"/> Epilepsy/Seizure Disorder     |
| <input type="checkbox"/> Reading and or Spelling Difficulties      | <input type="checkbox"/> Attention Deficit Disorder    |
| <input type="checkbox"/> Vision Problems                           | <input type="checkbox"/> Swallowing/Digestive Disorder |
| <input type="checkbox"/> Respiratory Difficulties (asthma,TB,etc.) | <input type="checkbox"/> Heart Problems/Stroke         |
| <input type="checkbox"/> Neurological Disorders                    | <input type="checkbox"/> Cancer                        |
| <input type="checkbox"/> Mental Illness                            | <input type="checkbox"/> Congenital Disorder           |
| <input type="checkbox"/> Hearing Problems                          | <input type="checkbox"/> Other                         |

Have you ever been seen by any of the following specialists? Check all that apply.

- |                                       |                                       |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Neurologist  | <input type="checkbox"/> Audiologist  |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Orthodontist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> ENT          |
| <input type="checkbox"/> Other        |                                       |

Please list physician's name and last date seen.

\_\_\_\_\_



**Present Communication Status**

Have you ever received a speech-language evaluation or treatments? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, by whom and what date/s? \_\_\_\_\_

\_\_\_\_\_

Diagnosis given on previous evaluation: \_\_\_\_\_

When did this communication problem first begin? \_\_\_\_\_

\_\_\_\_\_

Has the problem \_\_\_\_\_ remained the same \_\_\_\_\_ gradually worsened \_\_\_\_\_ worsened quickly?

Describe the severity of the disorder, does the severity vary? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Please check all statements that apply to your communication disorder:**

- interferes with my job performance
- interferes with my social skills
- interferes with my performance at school
- can express myself, others do understand me
- At times my speech improves, but it gets worse again
- difficulty recalling the names of common objects
- difficulty recalling the names of people and places
- easily understood by people I know
- easily understood by strangers
- frequently stumble over words, getting the sounds confused
- When I eat, the muscles in my mouth get sore and tired
- concerned about how people understand my speech
- My speech contains many word repetitions and prolonged sounds
- The pitch/loudness of my voice has changed
- difficulty singing
- often run out of breath while talking
- It takes a great amount of effort to talk

Overall, I would rate my communication as:

Excellent       Good       Fair       Poor

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you consider to be your greatest communication problem at this time?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**HIPAA Authorization Form**

**Patient Name (please print):** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**INDIVIDUALS  
ADDRESS** \_\_\_\_\_

I hereby authorize use or disclosure of protected health information as described below.

1. Advantage Therapy, LLC and its employees are authorized to use or disclose health information that is pertinent or required for Speech-Language/Occupational Therapy purposes.
2. Advantage Therapy, LLC may disclose health information considered pertinent to Speech-Language/Occupational Therapy to a patient's physician, teacher, or social worker.
3. I understand that Advantage Therapy, LLC will be disclosing protected health information to a patient's physician, teacher, and social worker (where necessary) and also understand that the information used or disclosed may be subject to re-disclosure by the individual or facility receiving the information.
4. I may revoke this authorization by notifying MELISSA PETERS AND OR ADVANTAGE THERAPY, LLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. This authorization expires when a patient is discharged by Advantage Therapy, LLC or receives a written desire to revoke it.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Signature



## **Advantage Therapy LLC's, Insurance Acceptance Policy**

We understand that you are seeking speech therapy services and you would like us to bill your insurance provider directly. While we are happy to proceed with this billing option, you may be responsible for a co-pay which will be billed monthly. You will also be considered responsible for any deductibles that may apply. Furthermore, if the insurance provider denies or fails to pay any claims, you will be responsible for payment of the services.

I have read and understand Advantage Therapy's Insurance Acceptance Policy and accept all terms and conditions.

---

Patient Signature

---

Date of Signature