DEPARTMENT OF SPEECH,
LANGUAGE, AND HEARING SCIENCES
1131 E. Second Street
PO Box 210071
Tucson, AZ 85721-0071

Clinic Main: 520-621-7070
Clinic Fax: 520-621-9901

Clinic for Adult Communication Disorders
Adult Medical (Neuro) Case History

Date Completed:___________________________

Name :____ Phone (home): ______________________

Address: ____

Phone (work, cell, message):____

Email address:____

City:_____________________________________State:_______________Zip Code:__________________________

Birthdate:__________Current Age:_____Sex:_____Gender/pronouns: ______________________________________

Contact Person:____Relationship: _____________________________

Contact Email:____ Phone: ___________________________

Did patient experience a stroke?_______a brain injury?_________ Date of stroke(s) or brain injury____________

Age at time of stroke or brain injury: _______ Slow onset of spch-language impairment ("PPA")? ________________

Referred Clinic by: ____

Hospital (acute care):___________________________________Physician at that time: ______________________

Rehabilitation Setting (include approximate dates):____

Current Primary Physician(s):_____________________________________Specialty:__________________________

Address:____Phone: __________________________

Marital Status: Single☐ Married☐__ Divorced☐__Widowed☐__ # of Children: Boys____Girls ________

Handedness (before onset): Right______Left____ Ambidextrous____ Is anyone in your family left-handed? Y/N

Primary language spoken now:______________________Primary language before onset: ____________________

First language learned:______________________Languages spoken other than English: ____________________

Occupation(s) (begin with most recent, include approx. # of years): ____________________________________

____

Highest Grade Completed:____________Degree(s): ____

If College degree(s), in what field(s)?_______________________From what institution(s)? ____________________

Where did this patient grow up? ____

Where has this patient lived as an adult? ____

Spouse's occupation: ____

If the patient had a stroke (brain injury/surgery), describe the events surrounding the event and the nature of the patient's problems soon after the event, include communication, thinking/memory, body weakness, changes in vision):

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Whether there was an event or not, describe the patient's current limitations with regard to communication, swallowing, vision, and physical skills:

			Describe
Difficulty swallowing	Yes	No	____________________
Difficulty communicating at basic levels	Yes	No	____________________
Difficulty with word finding	Yes	No	____________________
Difficulty understanding speech at basic levels	Yes	No	____________________
Difficulty understanding others at more complex levels	Yes	No	____________________
Slurred/imprecise speech	Yes	No	____________________
Changes in voice	Yes	No	____________________
Memory difficulties	Yes	No	____________________
Poor judgment (safety concerns)	Yes	No	____________________
Vision changes	Yes	No	____________________
Need for wheelchair/walker	Yes	No	____________________

Do those conditions include: Aphasia ________ Right sided weakness ________ Right sided paralysis?________

Seizures: _____ if yes, give date of last seizure: ________________

Does the patient wear glasses? ________ Has this patient had a visual examination since onset? ____________

Give name of eye doctor and date of last evaluation: ________________________________

Does this patient have a hearing loss?____________ Wear a hearing aid (R or L ear)? ______________

When and where was this patient's hearing last evaluated? ____________________________

Please continue onto the next page.

If the patient was previously enrolled in speech-language therapy, indicate the facility and the clinician's name(s) (if you recall them):

Current Medications, Purpose, and Dosage: (or send in a list)

Has the patient had a CT or MRI head scan? When and where was the most recent scan?

PRIOR to this patient's stroke (or the onset of communication difficulties), was there a history of any of the following?

			Describe
Communication Disorder	Yes	No	
Memory Impairment	Yes	No	
Head Injury	Yes	No	
Previous Stroke	Yes	No	
Clinical Depression	Yes	No	
Psychiatric Problems	Yes	No	
Alcohol Abuse/Problems	Yes	No	
Substance Abuse	Yes	No	
Dementia	Yes	No	
Other Neurological Disease	Yes	No	
Other Major Illness	Yes	No	

Please continue onto the next page.

Please provide some family and social information about this patient to help us better understand conversational topics of importance:

List important family members, friends, or pets:

____

____

____

What are some major accomplishments or highlights of this person's life?

____

____

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____

List hobbies or other topics of interest:

____

____

____

What are your expectations of this clinic?

____

____

____

Name of person completing this form: ____

Relationship to patient: ____