The Reading and Language Learning Center

8296 Old Courthouse Rd
Suite D
Vienna, VA 22182
703 830 1136
EIN# 26-0060915

ADULT CASE HISTORY FORM

Client's Name: _____
Today's Date: _____
Address:_____
City: _____ State: _____ Zip: _____
Telephone: (Home) _____ (Work) _____
(Cell)_____
E-Mail Address:_____

Date of Birth: _____ Sex: ____

Marital Status: S M D W

Employer: _____

Reason for Referral:
_____

Briefly Describe Problem: _____
_____
_____

SPEECH AND HEARING HISTORY

Please mark if you have a history of difficulty with any of the following:

Swallowing
Stuttered speech
Expressing Thoughts
Problem Solving
Maintaining Topic of Conversation
Memory
Focusing/Attending
Following Directions (processing information)
Reading/Writing
Slurred Speech
Word Finding

What do you expect to get out of therapy? (Please be specific):

_____

_____

_____

How do others react toward the problem:

_____

Is there a family history of this problem? Please explain:

_____

_____

Have you had previous speech therapy for this current problem? Please explain:

_____

_____

Has this problem improved/deteriorated since the onset? Please explain:

_____

_____

Person responsible for payment:

_____

Signature of Responsible Party:

_____

Date:

_____