Access Rehab Centers
A Waterbury Hospital & Easter Seals Partnership in Physical Rehabilitation

Thank you, for choosing Access Rehab Centers. We kindly request that you fill out all the necessary information for our therapists to complete a comprehensive evaluation. Please mail this packet back prior to the evaluation, if possible, so it can be reviewed.

SPEECH ADULT - CASE HISTORY FORM

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip: _____

Occupation: _____Business Phone: _____

Employer: _____

Referred by: _____ Phone: _____

Address: _____

Family Physician: _____ Phone: _____

Address: _____

Are you: ❑ Single ❑ Windowed ❑ Divorced ❑ Married - Spouse's Name: _____

Children: (include their name, gender and age)

_____

_____

_____

Who lives in the home?

_____

_____

What language(s) do you speak? Which is your dominant language? _____

_____

_____

What was the highest grade, diploma or degree you earned? _____

GENERAL INFORMATION

Describe your speech-language problem.

_____
_____
_____
_____

What do you think may have caused the problem?

_____
_____
_____
_____

Has the problem changed since it was first noticed? How? ❑ Yes ❑ No

_____
_____
_____
_____

Have you seen any other speech-language specialists? ❑ Yes ❑ No
If Yes, When and for how long?_____
What were their conclusions or suggestions?

_____
_____
_____
_____

Have you received any speech therapy while homebound? ❑ Yes ❑ No

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc)?
❑ Yes ❑ No
If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

_____
_____
_____
_____

Are there any other speech, language or hearing problems in your family? ❑ Yes ❑ No
If yes, please describe:

_____
_____
_____
_____

MEDICAL HISTORY

Provide the approximate ages at which YOU suffered the following illnesses and/or conditions:

Allergies	Asthma	Colds
Dizziness	Draining Ear	Ear Infections
Encephalitis	Headaches	Hearing Loss
High Fever	Influenza	Mastoiditis
Meningitis	Noise Exposure	Otosclerosis
Pneumonia	Seizures	Sinusitis
Tinnitus	Other	

Do you have any eating or swallowing difficulties? ❑ Yes ❑ No
If yes, please describe:

_____
_____
_____
_____

List all medications you are taking.

_____
_____
_____
_____
_____

Are you having any negative reactions to these medication? ❑ Yes ❑ No
If yes, please describe:

_____
_____
_____
_____

Describe any major surgeries, operations or hospitalizations and when they occurred.

_____
_____
_____
_____
_____

Describe any major accidents and when they occurred.

_____
_____
_____
_____
_____

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation process.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Use a separate sheet of paper if you need additional space.)

Person completing form: _____

Relationship to patient: _____

Signature: _____ Date: _____

Please return this packet of information by mail prior to the evaluation, if possible, so the therapists can review and prepare the necessary evaluation. If it is not possible to return these prior to the evaluation, please bring them with you on the day of the evaluation.

On the day of the evaluation, you will need:

- ✓ Insurance information
- ✓ Prescription from the physician ordering the therapy evaluation (if MD did not fax it directly to Access Rehab Centers.)
- ✓ Copy of any evaluations done by specialists (psychologist, neurologist, etc.)

Thank you for taking the time to fill out this important information. Please mail it back us as soon as possible to the address at the top of Page 1.

If this is not possible to mail this form, please be sure to bring it with you to the evaluation.