FAULKNER UNIVERSITY
CENTER FOR THERAPY AND RESEARCH

Speech Language Pathology

Adult Neurological Case History

Today's Date: ___________

Patient Information

Name:_________________________________ Date of Birth:____________ Age:_______

Address: _________________________________ City & State:________________ Zip:________

Home Phone:_________________________ Cell Phone: ___________________

Email: ______________________________

Present/Former Occupation: ___________________________

Spouse's name: ____

Members of the family: ____

____

Who lives with the patient: ____

Patient's level of education (last year completed): __________________________________

If you wish to have your report mailed to anyone other than yourself please fill out the information below.

Name: _____________________ Address: _____________________________________

City, State, and Zip Code: ____

Nearest Relative/Emergency Information

Name: ___________________________ Relationship: _________________________________

Address: ___________________________ City & State: ____________________ Zip: ________

Home Phone: _______________________ Other Phone: ____________________________

Referred By

Name: ________________________________ Phone Number: ___________________________

Address: _______________________________ City & State: _________________ Zip: _________

Visit Information

Description of Problem: ____

____

Current Diagnosis: ____

Major medical problems to present:____

____

____

____

Current Medications: ____

____

When did the accident/operation/illness occur: ____

Does the patient have paralysis?:_____________Describe:___________________________________

____

How does the patient get around (wheelchair, walker, etc.)?________________________________

Does the patient complain of headaches, faintness, or dizziness? _____________________________

____

Does the patient ever have convulsive seizures? _____________ If so, when was the last seizure?

____

Does the patient complain that he/she cannot see __________, hear _________, or feel _________

things properly? ____

Does the patient wear glasses? __________ Dentures? __________ Hearing aids? _____________

Describe the patient's communication skills? ____

____

What is the primary language of the patient? ____

Is there any other language spoken in the home?_______________ If so, what? ________________

Does the patient try to use words? _______________ Sentences? _____________ or does he/she

just point? ____________________

How well does the family understand what the patient is saying? Describe: ____________________

____

Does the patient talk as much as he/she did before the accident? ____________________________

How well does the patient write? Which hand does he/she use? ______________________________

____

Can the patient follow instructions? ____

Does the patient seem to understand what is said to him/her? _______________________________

Does he/she seem to understand what he/she reads? ______________________________________

Can the patient make change (money transactions)? ______________________________________

Does the patient seem to have difficulty solving basic problems? ____________________ Difficult

problems? ____

Does the patient have difficulty swallowing? Yes No

IF SO, please answer the following questions:

Describe your current diet: ____

____

Which of the following are EASIEST to swallow:

SOLIDS: (i.e., meat, raw fruits/vegetables, crackers)

PUREE: (i.e., applesauce, mashed potatoes)

LIQUIDS: (i.e., juice, water, coffee)

Are you unable to swallow any of the above? Yes No

If yes, which ones? ____

When eating, do you:

Have difficulty chewing your food?	Yes	No
Have difficulty moving the food from front to the back of the mouth?	Yes	No
After swallowing, does some food remain in the mouth?	Yes	No
Does food get “caught” in the throat?	Yes	No
Do you feel like you need to cough or get choked when eating?	Yes	No
Do you have difficulty swallowing pills?	Yes	No
Do you crush your medication?	Yes	No

If you answered yes to any of the above, please explain:

____

Have you ever had a swallowing evaluation? ____

If yes, where? ____

When? ____

Why? ____

What were the findings? ____

____

Related Complaints (Check appropriate items)	
• Ear/head noises	• Headaches
• Ear pain	• Dizziness
• Ear drainage	Onset _________
• Ear fullness	Duration _________
• Family hearing loss	• Nausea
• Vision	• Vomiting
• Chemo-therapy	• Noise exposure
• Speech problem	Type _________
• Language problem	Duration_______
• Difficulty with thin liquids	• Hearing protection
• Difficulty with solids	• Difficulty speaking
• Difficulty swallowing pills	• Slurred speech
• Other	
If you marked other, please explain:	

Illness (Check appropriate items)	
• Ear infections	• High blood pressure
• Ear surgery	• Stroke (CVA)
• High fever	• Circulatory problems
• Diabetes	• Anemia
• Low blood sugar	• Allergies
• Meningitis	• Upper respiratory infections
• Thyroid	• Head/neck injury
• Kidney	• Arthritis

Have you had or are you receiving any speech therapy?
____

Please explain when, where, and why you are/had speech therapy:

____

____

____

____

__

Other:

____

Remarks:

____

____

__

Interviewer: ____ Date: ____________________