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Speech-Language Development, SLP P.C.

Lyudmila Kimyagarova
Director

MACCC/TSHH P.R.O.M.P.T. trained-Level II
Speech-Language Pathologist
NYC License # 014994

CASE HISTORY FORM

Please fill out as completely as possible. This will assist us in completing our initial assessment and developing a treatment plan. Please feel free to ask for assistance.

PATIENT INFORMATION – *Please Print Clearly* **Date of Initial Visit: / /**

Patient Name: _____DOB:_____
(Last) (First) (Middle Initial)

Patient Social Security Number: ❒ Male ❒ Female **Age:**

Address:_____
(City) (State) (Zip Code)

Hm Phone: ( ) Cell Phone: ( )

Wk Phone: ( ) xt → Work phone is for:

E-mail:_____ Patient Marital Status: ❒ Single ❒ Married

Is the Patient Employed: Yes ❒ No ❒ Full-time ❒ Part-time

Employer: Occupation:

REFERRAL INFORMATION

How did you hear about us?_____

Referring Doctor:_____Facility:_____Ph #_____

Primary Care Doctor: Facility: Ph#

INJURY INFORMATION

Condition is related to ❒ Work ❒ Auto ❒ Home ❒ Birth ❒ Sports ❒ Other ❒ **None**

Date of Injury____/___/____Onset of Condition: Diagnosis_____

Body Side Affected: ❒ Right ❒ Left ❒ Both Body Parts Affected:

_____

_____

_____

Have you ever been hospitalized? Where? For how long?

_____

_____

_____

_____

Please list any medical conditions:

_____

_____

_____

Do you have any Allergies? Yes ❒ No ❒

Have you had any surgeries? Yes ❒ No ❒

Please list any health conditions you experience:

_____

_____

_____

Medications:

Name	***Amount (e.g., mg)***	***Frequency***	***Reactions***	***Reason for taking***

Language

Languages Spoken: English ❒ Other ❒ _____

Easily understood: Yes ❒ No ❒

Receptive Language (ability to understand what is being said):

❒ Normal ❒ Area of concern

Expressive Language (ability to speak):

❒ Normal ❒ Area of concern

Intelligibility (ability to articulate)

❒ Normal ❒ Area of concern

Is there any family history of Learning Disabilities, Attention Deficit (Hyeperactivity) Disorder, Emotional or Behavioral Difficulties and /or Neurological Disease?

Yes ❒ No ❒

Services Currently Receiving:

Services	**Frequency**	**Location (private)**
❒ Yes ❒No Occupational Therapy		
❒ Yes ❒No Physical Therapy		
❒ Yes ❒No Psychology		
❒ Yes ❒No Psychiatry		
❒ Yes ❒No Nutrition		
❒ Yes ❒No Vision therapy		

Is this your first speech and language evaluation?

Who referred you to Speech-Language Development?

What are your concerns? What brings you to seek an assessment?

What do you hope to achieve from our services?

Is there anything else that you would like us to know?

_____ _____

Signature Relationship to Patient/Date

I give permission for information from this Case History Form to be used in an evaluation report generated by Speech-Language Development SLP P.C.

_____

Signature/Date