UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Outpatient Rehabilitation Speech Language Pathology Department
Adult Communication - Case History
Si usted necesita un formulario en español, por favor, háganoslo saber.

Please fill out this form in blue or black ink as completely as possible and bring to your scheduled appointment.

**Identifying Information**

Name:_____Date:_____

Address:_____

Date of Birth:_____Age:_____Sex:_____Phone:_____

Employment or Retired from:_____

Highest level of education: ☐ GED ☐ High School Diploma ☐ Trade or Technical School Certificate

☐ Community College Degree ☐ Bachelors Degree ☐ Masters Degree ☐ Ph.D

Referred by:_____Physician Diagnosis:_____

Person completing from (relation to patient):_____

**Language History**

What is the chief complaint?_____

Please describe the nature of your communication problem_____

_____

When did the communication problem first begin?_____

What caused the problem?_____

Do you avoid social situations? ☐ NO ☐ YES

Describe any specific communications situations that present difficulty to you_____

_____

Is the Problem: ☐ Constant ☐ Wax and Wane

What, if anything, have you tried to do to correct the communication problem?_____

_____

Since the time of onset, have the symptoms: ☐ Worsened ☐ Persisted ☐ Improved

What prompted an evaluation?_____

Have you ever had a hearing evaluation?

☐ NO ☐ YES: By whom?_____

Please have these results faxed to our office (443-643-3212).

Have you ever had an evaluation or treatment by a Speech-Language Pathologist?

☐ NO ☐ YES: By whom?_____

Please have these results faxed to our office (443-643-3261).

If therapy was terminated, describe why:_____

_____

**Medical History - Please check all that apply**

☐ Heart Attack
☐ High Blood Pressure
☐ Cardiomyopathy
☐ Congestive Heart Failure
☐ Seizures
☐ COPD
☐ Anemia
☐ Heart Surgery
☐ Chemotherapy
☐ Diabetes
☐ Tracheostomy
☐ Polio
☐ Trauma
☐ Depression
☐ Alcohol Abuse
☐ Liver Disease
☐ Hepatitis/Jaundice
☐ Ulcers
☐ Kidney Disease
☐ Asthma
☐ Parkinson's
☐ Pneumonia
☐ Cancer
☐ Radiation
☐ Migraines
☐ Feeding Tube
☐ Influenza
☐ Head Injury
☐ Mania
☐ Panic Attacks
☐ Osteoporosis
☐ Broken Bones
☐ Neck/Back Pain
☐ Stroke/TIA
☐ Blackout/Dizziness
☐ Alzheimer's Dementia
☐ Bronchitis
☐ Glaucoma
☐ Shortness of Breath
☐ GERD
☐ Intubations
☐ Hydrocephalus
☐ Food/Drug Allergies
☐ Suicide Attempts
☐ Eating Disorder
☐ Schizophrenia
☐ Bipolar
☐ Other Psychological Problems

Other:_____

**Allergies**

Do you have any known allergies? ☐ NO ☐ YES: Please list them:_____

_____

**Current Health Practices**

Note any drugs used on a regular basis (both prescription and over the counter):

_____

_____

Past or present use of street drugs? ☐ NO ☐ YES: Please note:_____

Past or present use of tobacco?

☐ NO ☐ YES: Please note type and amount:_____

Are you exposed to second hand smoke? ☐ NO ☐ YES

Past or present use of alcohol?

☐ NO ☐ YES: Please note type and amount:_____

**Daily Routines**

Describe a typical day for you including household and daily responsibilities:_____

_____

Describe any assistance that you require with the following activities of daily living:

| **Skill** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Eating | | | |
| Mobility | | | |
| Toileting | | | |
| Grooming | | | |
| Dressing | | | |
| Medication | | | |
| Meal Preparation | | | |
| Shopping | | | |
| Housework | | | |
| Laundry | | | |
| Finances | | | |
| Home Repair/Yard Work | | | |
| Driving | | | |
| Other: | | | |

Do you still drive? If so, how often and approximate distances daily:_____

_____

**Social History**

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you have children? ☐ NO ☐ YES

If yes, please provide the information below:

| Name | Age | Gender | Name | Age | Gender |
|---|---|---|---|---|---|
| | | M F | | | M F |
| | | M F | | | M F |
| | | M F | | | M F |

**Advanced Directives**

a) Generally patients that would experience a medical emergency in outpatient rehab are treated as a full code.

b) Only patients with MIEMSS (Maryland Institute for Emergency Medical Services Systems) protocol or MOLST (Maryland Medical Orders for Life Sustaining Treatment) documentation on their person will be treated as indicated in those orders. (May be incorporated into a necklace or bracelet)

c) If you have questions concerning Advanced Directives, please talk to your therapist. We can provide you with information or refer you to Guest Services for further assistance.

Thank you for taking the time to complete this form in its entirety. The information that you have provided will assist us in delivering efficient and effective Speech-Language Services.

_____

Signature of the person completing this history form:

_____Date:____/____/____

Reviewed By:_____Date:____/____/____