

Case History Form - Teens & Adults

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Referral Source: _____

What is/are your concern(s)? _____

Physicians' name and address: _____

Personal History

Occupation: _____

Place of Birth: _____

What is/are your concern(s)? _____

Who lives in the home? (list below)

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

What languages are spoken at home? _____

Is there any history of speech or language problems in the family? **Yes [] No []**

If yes, please describe: _____

Describe any significant family medical, learning or emotional history. _____

Have you seen any additional specialists? **Yes** [] **No** []

Medical History

Have you been hospitalized? **Yes** [] **No** []

If so, include age, reason and length of stay: _____

History of illness, including age: _____

History of accidents, including age: _____

How would you describe your general health? _____

Are you taking any medications? **Yes** [] **No** []

If yes, what kind and why: _____

Have you had your hearing tested? **Yes** [] **No** []

If yes, when and what are the results? _____

As a child, how was your health? _____

Medical history: please check all that apply:

- | | | | |
|--|-----|---------------------------|-----|
| Frequent congestion | [] | Mouth breather | [] |
| Allergies | [] | Heartburn | [] |
| Asthma | [] | GERD/ Reflux | [] |
| Difficulty swallowing | [] | Headaches | [] |
| Frequent sore throats | [] | Constipation | [] |
| Ear popping | [] | Ear infections (as adult) | [] |
| Tinnitus (ear ringing) | [] | Dizziness | [] |
| Frequent nausea | [] | Dry/ bloody nose | [] |
| Sinusitis | [] | Motion sickness | [] |
| Frequent stomachaches | [] | | |
| Frequent colds or upper respiratory infections | [] | | |

Dental history: please check all that apply:

- | | | | |
|----------------------------|-----|------------------------|-----|
| Cavities | [] | Root canals | [] |
| Gun disease | [] | Excessive wear | [] |
| Chipped tooth/teeth | [] | Mouth sores-canker | [] |
| Mouth sores-herpes simplex | [] | Halitosis (bad breath) | [] |
| Gingivitis | [] | Inflamed gums | [] |
| Bleeding gums | [] | Excessive plaque | [] |
| Teeth grinding | [] | Jaw pain | [] |
| Wisdom teeth extraction | [] | Orthodontia | [] |

Functional Information

Do you have any feeding difficulties or history of feeding issues as a child? (e.g., drooling, swallowing). **Yes** [] **No** []

Do you avoid any foods? **Yes** [] **No** []

Do you have any oral habits such as nail biting? **Yes** [] **No** []

Did you or do you currently use a pacifier or suck your thumb? **Yes** [] **No** []

Do you grind your teeth? **Yes** [] **No** []

Do you breathe through your nose? **Yes** [] **No** []

When you sleep do you (have)?

- Snore [] Drool [] Wake up with head or jaw pain [] wake frequently []
feel tired all day [] sleep walk [] have night terrors [] restless legs []

restless [] light sleeper [] difficulty falling asleep []

Have you had orthodontia or dental problems other than indicated in the dental history?

Yes [] No []

Do you have any sensory issues, such as sensitivity to smell, light, and touch?

Yes [] No []

Do you have any balance or coordination difficulties? Yes [] No []

If yes, please describe. _____

How clear do you feel your speech is? _____

Is there any other information about you that may be helpful in this evaluation? (Explain below and on back please)