ADULT CASE HISTORY FORM

Name: _____
Indicate which therapy you would like:

_____Physical Therapy _____Occupational Therapy _____Speech-Language Pathology

Reason for services: _____

Do you have a medical diagnosis or reason for referral from your doctor? If so, what is it?

_____

Please list any surgeries or hospitalizations & describe: _____

_____

Do you have difficulty with any of the following:

Speech Areas	**Yes / No** no	**Occupational Therapy Areas**	**Yes / No** no	**Physical Therapy Areas**	**Yes / No** no
Swallowing		Buttoning		Getting in and out of cars	
Coughing or choking		Putting on your own shoes & socks		Walking	
Speaking loudly		Getting dressed by yourself		Sitting up	
Understanding others		Brushing your teeth		Getting into and out of bed	
Having others understand you		Using the toilet by yourself		Pain	
Remembering things		Raising your arms		weakness	
Having a raspy voice		Opening doors		Bending or stooping	
Stuttering:		Pain		Feeling dizzy	
Other:		Other:		Other:	

What would you hope to gain from therapy services? _____

_____

Do you have any particular concerns for therapy? _____

This information is true and correct to the best of my abilities / knowledge.

_____ _____

Patient or Caregiver Signature Date