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)