AUBURN TLC
Therapy And Learning Center

Adult Case History Form

Welcome to Auburn TLC! In order to help us achieve our mission of providing the highest quality treatment, please complete this form as accurately as possible. We look forward to working with you.

Today's Date: _____

General Information

Client Name: _____ Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Referral Source: _____

Reason for the evaluation: _____

_____

Physician's Name: _____ Phone number: _____

Person completing this form: _____ Relationship to client: _____

Preferred language: _____

How has the speech/language difficulty affected the client? _____

_____

Family Information

Please check all that may apply:

_____ Single _____Married _____ Widowed _____ Divorced _____Separated _____Remarried

Please list the names and ages of the client's children:

Name	Age	Gender

Education and Work Information

What is the client's highest level of education? _____

Client's Occupation and Employer: _____

Is the client currently working? _____ Yes _____ No

Briefly describe client's responsibilities outside of work environment: _____

Please complete the following chart pertaining to the client:

	YES	NO
Communicate Verbally		
Communicate in Writing		
Verbalize Name and Address		
Write Name and Address		
Intelligible Writing		
Verbalize Short Sentences		
Write Short Sentences		
Understands Conversations		
Read the Newspaper		
Initiate Conversations		

Is there a concern about aphasia, stroke or head injury? If yes, please explain: _____

_____

Medical Information

Has client received speech/language therapy, occupational therapy or physical therapy in the past? If so, where and for what reasons? _____

_____

What medications is the client currently taking? _____

_____

Does the client wear glasses? _____ Yes _____ No

Does the client have any hearing difficulties? _____ Yes _____ No

Does the client wear hearing aids? _____ Yes _____ No

Does the client have a history of any of the following?

	YES	NO
Stroke		
Aphasia		
Other Communication Disorder		
Right or Left-Sided Weakness		
Dementia (i.e., Alzheimer's)		
Memory Impairment		
Other Neurological Difficulties		
Head Injury		
Seizure Disorder		
Clinical Depression		
Psychiatric Problems		
Alcohol/abuse Problems		
Other Substance Abuse		
Other Major Illnesses		

What are the expectations for this evaluation and treatment? _____

_____