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Azalea Rehab Services

2717 Windemere Drive, Suite A Valdosta, GA 31602

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Case History Form

General Information:

Patient's Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **Zip Code:** _____

Spouse (if applicable): _____

Home phone #: _____ **Work phone #:** _____

Cell phone #: _____

Emergency Contact Name: _____

Emergency Contact #: _____

Physician's Name: _____

Physician's Address and Phone Number: _____

Physician Fax Number: _____

Insurance: _____

Insurance Address and phone #: _____

Co-Pay: _____ **Member ID:** _____ **Group #:** _____

Name and DOB of Insured (if other than patient): _____

Referred By: _____

When was the problem first noticed? By whom?

_____

_____

Are there any other speech, language, or hearing problems in your family? If so, please describe.

_____

_____

Medical History

Other Specialists/Physicians That See the Patient: _____

_____

Illnesses, Injuries, Operations (Date, Severity, Complications): _____

_____

HEARING: DATE TESTED: _____ RESULTS: _____

VISION: DATE TESTED: _____ RESULTS: _____

Allergies: _____

Current Medications: _____

_____

Other Information: _____

_____

_____

Difficulty you experience (circle all that apply):

Swallowing **Voice** **Hearing** **Speaking** **Understanding Others**

Memory **Word finding** **Stuttering**

Other: _____

Onset Date (when the problem first began): _____

When do you have the <u>LEAST</u> difficulty: _____

_____

When do you have the <u>MOST</u> difficulty: _____

_____

How do you cope: _____

_____

What is YOUR goal for therapy: _____

_____

Have you had therapy previously: YES NO

Where: _____

Dates: _____

Do you have any adaptive equipment (brace, walker, wheelchair, special cup for drinking, electrolarynx, etc.): _____

_____

Other (Please include any other information you feel would help us better understand your difficulties):

_____
_____
_____
_____

***Person completing form:* _____**

***Relationship to client:* _____**

***Signed:* _____ *Date:* _____**