

Kimeshree Moodley Speech-Language Therapist

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NDT, PROMPT, DIR Floortime & Makaton Trained



**Project
COMMUNICATE**
Speech-Language Therapy
COMMUNICATION • FEEDING • COGNITION

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SPEECH-LANGUAGE THERAPY CASE HISTORY FORM - ADULT

GENERAL INFORMATION

Client name & surname:	
ID number:	
Date of Birth:	
Contact number:	
Email Address:	
Age:	
Employment:	
Marital Status :	
Partner / Next of Kin:	
Contact number:	
Email Address:	
Family Doctor:	
Contact Information:	
Preferred language/s of communication:	

BACKGROUND INFORMATION

What are your current concerns regarding your speech, language, swallowing, or motor skills?	
What do you think caused the above difficulties?	
When was the problem first noticed?	
Has the problem changed (worsened/ resolved) since it was first noticed? Please describe.	
Have you ever seen a specialist/therapist regarding these difficulties? Please elaborate if you are willing to share this information.	

MEDICAL HISTORY

What is your current medical diagnosis?	
Do you/have you suffered from any illnesses or medical conditions? If yes, please elaborate	
Have you ever had surgery or been hospitalized for any reason? If yes, please elaborate	
Are you currently taking any medications? Please list.	
Do you have any known allergies? (medications, foods, latex, seasonal, etc.) Please list.	
Has your hearing been evaluated? If so, indicate where, when, and the status of that evaluation.	
Has your vision ever been evaluated? If so, indicate when, where, and the status of that evaluation.	

Compiled by: Fahmeedah Desai (SLT)

Is there anything else you wish to share regarding your medical history?	
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FAMILY / SOCIAL HISTORY

Who do you live with?	
Is there any family history of speech, language, swallowing, hearing, cognitive or mental health issues?	
If yes, please elaborate on the above.	
Please describe your past/current occupation if applicable	
What are your hobbies/interests?	
How do you usually spend your day/time?	
How often do you go out for visits/socialise with others in the community, etc.?	
Do you require assistance with any of the following activities? <ul style="list-style-type: none"> • Dressing • Toileting • Money Management • Bill Payments • Cooking • Transportation • Driving • Keeping track of appointments • Eating • Showering • Personal Hygiene • Moving • Walking from place to place/ • Telling time • Making phone calls • Grocery shopping • Housekeeping (etc.) Please elaborate.	

COMMUNICATION/ SWALLOWING/COGNITIVE HISTORY

What are your current concerns regarding your speech, language, swallowing, or cognitive skills?	
Do you have difficulty expressing your wants and needs? If yes, please elaborate.	
Do others find you difficult to understand? If yes, please elaborate	
Do you find it hard to understand others? If yes, please elaborate.	
Do you have short-term and/or long-term memory difficulties? If yes, please elaborate.	
Do you have difficulty with word-finding (i.e., remembering the names of objects and/or people)? If yes, elaborate.	
Have there been any changes to your voice (i.e., hoarse, breathy, loss of volume)? If yes, please elaborate.	
Do you feel like your speech sounds slurred or unclear at times? If yes, please elaborate.	

Do you have any difficulties with reading/writing? Please elaborate.	
Do you have any difficulties at mealtimes (with chewing, swallowing, etc.)?	
If yes, are these difficulties related to solid foods/liquids? Please provide examples, e.g. bread, water	
Have you experienced incidents of coughing/choking/vomiting during feeding?	
Please share any additional information that might be relevant:	

Person completing the form:	
Relationship to client (if applicable):	
Signature:	
Date:	

*Thank you for taking the time to complete this Case History form.
It is highly appreciated and will provide our team with valuable insight.*

With kindness,

**Speech-Language Therapist
Project Communicate Speech-Language Therapy**