COMMUNITY AUTISM SERVICES
THE STEPPING STONES GROUP

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ADULT CASE HISTORY FORM

Today's Date:

GENERAL INFORMATION

Name	Date of Birth
Email Address	Age
Phone	

Street Address:

City: State: Zip Code:

Occupation: Business Phone:

Employer:

Referred By: Phone:

Address:

Family Physician: Phone:

Address:

Type 'YES' in the box if: Single Widowed Divorced

Domestic Partnership Married

Spouse's/Partner's Name:

Children (include names, gender and ages):

Who lives in the home?

What languages do you speak? If more than one, what is your dominant language?

What was the highest grade, diploma or degree you earned?

Describe your speech-language problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Have you seen any other speech-language specialists? Who and when? What were their conclusions or suggestions?

Have you seen other specialists (physicians, audiologists, psychologists, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

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

MEDICAL HISTORY

Provide the approximate ages at which you suffered the following illness or conditions.

Adenoidectomy:	Asthma:	Chicken pox:
Colds:	Croup:	Dizziness:
Draining ear:	Ear infections:	Encephalitis:
German measles:	Headaches:	Hearing Loss:
High fever:	Influenza:	Mastoiditis:
Measles:	Meningitis:	Mumps:
Noise exposure:	Otosclerosis:	Pneumonia:
Seizures:	Sinusitis:	Tinnitus:
Tonsillectomy:	Tonsillitis:	Other:

Do you have any eating or swallowing difficulties? If yes, describe.

List all medications you are taking.

Are you having any negative reactions to these medications? If yes, describe.

Describe any major surgeries, operations or hospitalizations (include dates).

Describe any major accidents.

Provide any additional information that might be helpful in the evaluation or remediation process.

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Person completing the form:	Relationship to the client:

Today's Date:

Signature (typing your name here indicates your signature):