IDENTIFYING & FAMILY INFORMATION

Person filling out this form (circle one): Patient Other: _____

Patient's Name: _____ **Patient's DOB:** _____

Patient's Sex: ☐ Male ☐ Female **Patient's Email Address:** _____

Patient's Address: _____

_____

Patient's Cell Phone: _____ **Patient's Phone Number:** _____

Occupation/Employer_____

Highest level of education (grade or degree) completed: _____

Marital Status: _____ **Spouse/Partner's name (if applicable):** _____

Children (if applicable):

Name	Age

Emergency Contact Name: _____

Emergency Contact Email: _____

Emergency Contact Cell Phone Number: _____

Emergency Contact Other Phone Number: _____

Emergency Contact Address: _____

_____

Referring Doctor's Name and Address: _____

_____

Referring Doctor's Phone and Fax Numbers: _____

Is the patient followed by any other medical doctors? If so, who? _____

_____

_____

Are any languages other than English spoken in the home? ☐ **Yes** ☐ **No**

If yes, which one(s)? _____

What language does the patient prefer to speak? _____

MEDICAL HISTORY

List any medications the patient takes: _____

_____

_____

List any allergies: _____

Does the patient use any of the following assistance devices?

- ☐ Wheelchair
- ☐ Cane
- ☐ Walker
- ☐ Other _____

Has the patient been diagnosed with/had any of the following?

- ☐ Acid Reflux
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
  - Type_____
- ☐ Cerebral Palsy
- ☐ Chronic colds
- ☐ Chronic laryngitis
- ☐ Cleft Palate/Lip
- ☐ COPD
- ☐ Diabetes
- ☐ Ear infections
- ☐ Emotional or psychological issues
- ☐ Facial Nerve Palsy
- ☐ Head Injury
- ☐ Hearing loss
- ☐ Heart troubles
- ☐ Huntington's or Parkinson's Disease
- ☐ Hypertension
- ☐ Intellectual deficits
- ☐ Meningitis
- ☐ Multiple sclerosis
- ☐ Neurological conditions
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sinusitis
- ☐ Stroke
- ☐ Traumatic Brain Injury
- ☐ Tuberculosis

☐ Vocal polyps or nodules

☐ Voice issues or changes

Other medical diagnosis(es) and serious injury(ies): _____

_____

_____

Has the patient been seen by any other rehabilitation professionals?

☐ **Speech therapy**: where: _____ when: _____

☐ **Physical Therapy**: where: _____ when: _____

☐ **Occupational Therapy**: where: _____ when: _____

SPEECH-LANGUAGE INFORMATION

What is the main concern regarding the patient's speech and language?

_____

_____

_____

_____

Speech and Language Concerns: Check the box that best describes the patient's speech and language abilities.

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty with your sounds being understood			
Difficulty understanding what others are saying			
Difficulty with orientation/memory			
Difficulty with problem solving			
Difficulty focusing/paying attention			
Difficulty with finding words to use			
Difficulty maintaining topic of conversation			
Stuttering while speaking			
Oral motor weakness (difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties (hoarseness, volume, etc.)			

Are there any other speech/language difficulties besides what is listed above?

If yes, please describe _____

_____

_____

_____

_____

When was this problem first noticed and by who? _____

Did the problem begin suddenly or develop over time? _____

Does the patient's speech/language impact their ability to function in daily life? If yes, how or where does the speech-language difficulty impact them the most?

_____

_____

_____

_____

_____

_____

_____

_____

Describe the patient's daily communication needs:

_____

_____

_____

_____