CLIENT HISTORY –

(Please complete the form to the best of your ability and bring it to your first appointment)

Today's Date: ___________

Name: _______________________________ Gender: ______

Age: ______ Birthdate: ________________

Home phone: (___)-___-_________ Cell phone: (___)-___-_________.

May I email you? If so provide email: __________________________

Mailing Address_____________________________ City___________ State_____

Zip Code______________

Emergency Contact__________________ Phone Number (___)-___-__________

Relation to Patient __________________

Occupation______________________________ Employer____________________________
Years of Education_______________________

Insurance Information:

Name of Insurance Company:____________________ Patient ID:____________________

Group Number: ____________________ Do you have secondary insurance? Y/N

Primary Care Physician

Name _____________________________________

Mailing Address_____________________________ City___________ State_____

Phone Number ___________________ Fax_________________

Personal History

Please list any allergies: ____

Language(s) spoken in the home: ______________________________

Are you hard of hearing? (Y/N) ______ Do you wear hearing aids? (Y/N) ______

Briefly describe why you are here:

What are your goals for treatment?

Previous experience with a speech therapist? (Y/N)

Any other comments or questions?

Presence of personal or family medical problems (Check if yes)

Condition	Personal History	Family History
Acid Reflux		
Attention Deficit Disorder		
Autism		
Cancer		
Dementia		
Diabetes		
Difficulty Swallowing (dysphagia)		
Dyslexia		
High blood pressure		
High Cholesterol		
Parkinson's disease		
Stroke		
Traumatic Brain Injury		
Urinary Tract Infections		

Do you have other medical conditions I should be aware of? If yes, please provide a list below

What medications do you take? Please bring a list of medications to your first appointment or fill out the information below. If you need more space, please write on the back of this page.

Medication name	Dosage	How Often

Patient Printed Name

Patient Signature | Date

Signature of Consenting Party | Relationship to Patient | Date