PATHWAYS
SPEECH THERAPY INC.

Name: _____ DOB: _____

Current Status / History

Current Status

Please describe your present issue: _____

_____

Are you here due to an accident or injury? □Yes □No Date of occurrence: _____

Is this related to a Work Comp claim? □Yes □No

Describe: _____

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: _____

What are you expecting out of this evaluation? _____

_____

Have you ever had a previous speech, language or feeding evaluation / treatment?

□Yes □No By whom: _____When: _____

Describe the results: _____

Has the problem improved or gotten worse? Describe: _____

_____

When did you first notice the problem? _____

Do you use any strategies to help with this problem? _____

_____

History

Describe any pertinent medical/surgical history: _____

_____

_____

Have you ever been hospitalized for a related issue? □ Yes □ No

Please describe: _____

{Continue to back}

Have you ever been in a serious accident? ☐ *Yes* ☐ *No*

Please describe if so: _____

Please list the medications that you are taking: _____

_____

Please list any allergies: _____

Check and describe all that apply:

☐ Anxiety
☐ Asthma
☐ Attention Deficit Disorder
☐ Brain injury
☐ Breathing problems
☐ Cancer
☐ Cognitive Issues
☐ Congestive Heart Failure
☐ COPD
☐ Degenerative illness
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Ear infections
☐ Hearing Loss
☐ Heart Attack
☐ Hypertension
☐ PEG tube/G-tube
☐ Pneumonia
☐ Psychiatric issues
☐ Reflux/Heartburn
☐ Respiratory problems
☐ Seizures
☐ Stroke / TIA
☐ Swallowing problems
☐ Other: _____
_____

Have you ever been evaluated by the following specialties? Check all that apply:

☐ Audiologist
☐ ENT
☐ Gastroenterologist
☐ Occupational Therapist
☐ Physical Therapist
☐ Psychiatrist/Psychologist
☐ Pulmonologist
☐ Speech Therapist

If you checked any, please describe any findings: _____

_____