Patient Name: _____ Date of Birth: _____ Date of Eval: _____

SUBJECTIVE

Why are you seeking Speech Therapy treatment? _____

_____

Other language(s) besides English spoken in the home: _____

What are your communication needs in social settings? _____

_____

What difficulty do you have meeting your communication needs? _____

_____

Have you had any prior treatment and/or diagnostic testing for this condition? □ Yes □ No

If Yes, please explain: _____

_____

Do you currently use an alternative / augmentative communication device? □ Yes □ No

If yes, was the device purchased through insurance? □ Yes □ No

Date of next Doctor's appointment: _____

THERAPIST COMMENTS:

CURRENT COMPLAINTS

What is your chief complaint (i.e., language, swallowing, etc.)? _____

_____

_____

THERAPIST COMMENTS:

FUNCTIONAL/ADL ABILITY RESTRICTIONS

Do you have trouble understanding others?	□ Yes □ No
Do others have trouble understanding you?	□ Yes □ No
Do you stumble or stutter over words?	□ Yes □ No
Is your voice unusually harsh or "breathy"?	□ Yes □ No
Do you have trouble naming objects or following simple directions?	□ Yes □ No
Do you have the feeling of choking while eating?	□ Yes □ No
Do you cough during meals with foods or fluids?	□ Yes □ No
Do you have difficulty with short or long term memory?	□ Yes □ No
Do you forget common things frequently?	□ Yes □ No

THERAPIST COMMENTS:

OCCUPATION/WORK STATUS

What is your occupation? _____

Are you presently working? □ Yes □ No If Yes, □ Full Duty □ Limited Duty

Explain: _____ # Lost Days of Work:_____

Describe your current job setting and your communication needs: _____

_____

How do communication problems affect your current job? _____

_____

How have communication difficulties affected the types of jobs you have held? _____

_____

Does your communication difficulty affect your future job plans? □ Yes □ No

If Yes, please explain:_____

Are you now, or have you ever been disabled (service or work)? □ Yes □ No

If Yes, when? _____

THERAPIST COMMENTS:

MEDICATIONS

Please list all of the medications (with specific dosages) that you are currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals): _____

_____

_____

THERAPIST COMMENTS:
□ See Attached List

SOCIAL HISTORY/INTERESTS/LIVING ENVIRONMENT

Do you live: □ Alone □ Spouse □ Partner □ Family □ Other _____

Do you have any children? □ Yes □ No If Yes, how many? _____

If Yes, what are their ages? _____

Are there any speech or hearing problems in the family? □ Yes □ No

If Yes, please explain: _____

Do you have any hobbies? □ Yes □ No If Yes, please list: _____

Do you participate with any social and/or civic groups? □ Yes □ No

If Yes, please list: _____

THERAPIST COMMENTS:

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? □ **Good** □ **Fair** □ **Poor**

Do you have, or have you ever had any of the following? (Please check ALL that apply)

□ Allergies	□ Encephalitis	□ Multiple Sclerosis
□ Asthma/Breathing Difficulties	□ Acid Reflux	□ Osteoporosis
□ Bronchitis	□ Osteoarthritis	□ Pacemaker
□ **Cancer**	□ **Head Injury**	□ Parkinson's Disease
□ Chest Pain/Angina	□ Headaches	□ Physical Abnormalities
□ Deep Brain Stimulator	□ Heart Disease	□ **Pneumonia**
□ Chronic Colds	□ High/Low Blood Pressure	□ Polio
□ Chronic Laryngitis	□ Hypoglycemia	□ Pregnancy (Currently)
□ Congenital Defects	□ **Stroke/TIA**	□ Tonsillitis
□ **Depression**	□ Meningitis	
□ Diabetes I or II	□ Seizures/Epilepsy	
□ **Dizziness/Fainting**	□ Early Onset Dementia	
□ Ringing of the Ears	□ Smoking History	
□ Sinusitus	□ Thyroid Disease	
□ Surgeries	□ **Unexplained Weight Loss/Gain**	

□ Other: _____

Is there any other information regarding your medical history that we should know about?

_____

Do you have any of the following? If Yes, please explain in the space provided:

Dental Problems □ **Yes** □ **No** **Describe:** _____
Earache/Ear Infections □ **Yes** □ **No** **Describe:** _____
Hearing Difficulties □ **Yes** □ **No** **If Yes, Aided?** _____
Vision Problems □ **Yes** □ **No** **If Yes, Treatment?** _____

Hand Dominance □ **Right** □ **Left** □ **Ambidextrous**

THERAPIST COMMENTS:
□ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? _____
_____
_____
_____

THERAPIST COMMENTS:

OTHER RELATED INFORMATION

THERAPIST USE ONLY: _____

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____
Therapist's Signature: _____ **License #:** _____ **Date:** _____
Printed Therapist's Name: _____