Patient Information

Date: _____

Patient's Name: _____ Age: _____

Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ E-mail: _____

Cell Phone: _____ Work Phone: _____

Occupation: _____

Employer: _____

Employer's address: _____

Single ____ Widowed ____ Divorced ____ Married ____ Other ____

Spouse's Name: _____

Children (include names, genders and ages):

_____
_____
_____
_____

Who lives in the home? _____

What languages do you speak? If more than one, which is your primary language? _____
_____

Existing Diagnosis: _____

Referred by: _____

How did you hear about us?
_____

Patient's Primary Physician Name:
_____

Practice Name:
_____

Address:
_____
_

Phone: _____ Fax:
_____

Concerns

Describe the problem for which you are referred and your concern as it relates to your speech, language, voice or swallowing:
_____

_____
_____
_____

What do you think may have caused the problem?
_____

_____
_____
_____

When did you first notice the problem?
_____

_____
_____
_____

Has the problem changed since it was first noticed?
_____

_____
_____
_____

Have you see any other speech-language specialists? Who and when? What were the results?
_____
_____
_____
_____
_____

Have you seen any other specialists (physicians, psychologists, neurologists, etc.)? If yes, indicate the name, type of specialist, etc.
_____

_____
_____
_____

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

_____
_

_____
_____
_____

Medical History

Please check any of the following illnesses and conditions you may have had and provide the approximate age:

Asthma ____ Chicken Pox ____ Convulsions ____ Frequent colds ____ Stroke ____

Hearing loss____ Ear infections ____ Noise exposure ____ Otosclerosis ____

Seizures ____ High fever ____ Tonsillitis ____ Sinusitis ____ Frequent Bronchitis ____

TBI ____ Pneumonia ____

Allergies____ To what?

_____

Other

_____
____

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

_____

_____
_____
_____
_____

Did you undergo any swallowing tests recently (Modified Barium Swallow Study or Fiber-Endoscopic Evaluation of Swallowing)?

_____

List medications you are taking:

_____

_____
_____

List any major surgeries, operations, or hospitalizations and dates they occurred:

_____
_____
_____
_____

List any major accidents and when they occurred:
_____

_____
_____
_____

Please provide any additional information that may be helpful in the evaluation or therapy process:

_____
_____
_____

Please return this form along with copies of any previous evaluations, or other reports you would like us to consider.

Thank you!