

GENERAL INFORMATION:

DATE: ____ / ____ / ____

NAME:		DATE OF BIRTH:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME #:	CELL #:	OTHER CONTACT#:	
OCCUPATION:	EMPLOYER:	WORK #:	
EMAIL ADDRESS:			
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:	
<input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> MARRIED - SPOUSE'S NAME:
CHILDREN (INCLUDE NAMES, GENDER, AND AGES):			

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY.

GENERAL INFORMATION:

• Who lives in the home?

• What languages do you speak? If more than one, which one is your dominant language?

• What was the highest grade, diploma, or degree you earned?

• Is there any problem with you language skills (ability to find the right words, express yourself, or understand others)?

• Have you noticed changes in your cognition (memory, clarity, and speed of thinking, problem solving, or planning skills)?

• Is there any problem with your speech (ability to produce clear speech sounds by the oral mechanism)?: _____

• What do you think may have caused the problem? _____

• Has the problem changed since it was first noticed? _____

• Have you seen other speech-language specialist? Who and when? What were their conclusions or suggestions?

• Have you seen any other specialists (physicians, audiologist, psychologist, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions:

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

MEDICAL HISTORY:

- Provide the approximate ages at which you suffered the following illnesses and conditions:

Adenoidectomy _____	Asthma _____	Chicken Pox _____
Colds _____	Croup _____	Dizziness _____
Draining ear _____	Ear infections _____	Encephalitis _____
German Measles _____	Headaches _____	Hearing Loss _____
High fever _____	Influenza _____	Mastoiditis _____
Measles _____	Meningitis _____	Mumps _____
Noise Exposure _____	Otosclerosis _____	Pneumonia _____
Seizures _____	Sinusitis _____	Tinnitus _____
Tonsillectomy _____	Tonsillitis _____	Other: _____

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

- List all medications you are taking:

- Are you having any negative reactions to these medications? If yes, describe: _____

- Describe any major surgeries, operations, or hospitalizations (include dates):

- Describe any major accidents:

- Provide any additional information that might be helpful in the evaluation or remediation process:

ALLERGY INFORMATION:

- Do you have any known allergies (e.g., foods, medicines, environmental agents)? If yes, please list and describe your response to contact with the allergen(s): _____

- Please describe immediate action to be taken in case of contact with allergen(s) _____

- Person to contact in case of Emergency: _____ Phone #: _____

To the best of my belief, this information is true and correct.

Person completing form: _____ **Relationship to patient:** _____

Signed: _____ **Date:** _____