Patient Name: ______________________ Date of Birth: _____________

Address: ____

City: ____________________________ State _______ ZIP _____________

Employer: ____

Primary Language: ____

Referred By: ____

Primary Doctor: ____

Reason for evaluation:

- ☐ Slurring Sounds when Speaking
- ☐ Difficulty Retrieving Words
- ☐ Memory/Attention
- ☐ Difficulty Understanding Others
- ☐ Groping for Sound when Speaking
- ☐ Other: ____

Past Medical History – please provide a date of onset for any YES responses.

Autism YES NO
ADHD YES NO
Asthma/COPD YES NO
Allergies YES NO
Bronchitis YES NO
Cardiac Disease YES NO
Chemotherapy YES NO

Laryngitis YES NO
Learning Disability YES NO
Lung Cancer YES NO
Oral/Tonsil Cancer YES NO
Pneumonia YES NO
Radiation Therapy YES NO
Shortness of breath YES NO
Seizures YES NO

Cerebral Palsy YES NO
Cleft Palate YES NO
Dementia YES NO
Diabetes YES NO
Gastric Reflux YES NO
Head/Neck Cancer YES NO
Head/Neurological Injury YES NO
Hearing Loss YES NO
High Blood Pressure YES NO
Kidney Disorder YES NO
Leukemia YES NO
Sleep Apnea YES NO
Speech/Lang Impairment YES NO
Stroke (CVA/TIA) YES NO
Swallowing Problems YES NO
Thyroid Cancer YES NO
Tracheostomy tube YES NO
Thyroid Disease YES NO
Visual Impairment YES NO
Voice Impairment YES NO
Ventilator Dependency YES NO

How do you take Medication? With water • In puree
•Other: ________________________ List medications or attach list:

____

____

____

Please circle any of the following specialists seen in past:
• Physical or Occupational Therapist • Ear Nose and Throat Specialist • Eye Specialist • Neurologist • Speech/Language Pathologist • Audiologist/Hearing

<u>Family and Social History:</u> Please circle all that apply:
• Working • Student • Unemployed • Retired • Live alone

Onset date of communication difficulty: ________________________
□ Gradual onset □ Sudden onset

Did communication concern follow an illness/family problem/traumatic event? □ NO □ YES
If yes, please explain:

____

Has it changed over time? □ NO □ YES: □ Worse □ Better
Able to read/understand: □ Words □ Sentences □ News articles □ Books
Current Communication: □ Speech □ Writing □ Gestures □ Communication Board
Trouble hearing: □ NO □ YES: □ Hearing Aids
Voice change: □ NO □ YES: □ Hoarse □ Breathy □ Strained □ Too Soft □ Other: ____

Do you have trouble with any of the following? Please circle all that apply.

Finding the right word □ NO □ YES:

Getting to the point □ NO □ YES:

Organizing your thoughts□ NO □ YES:

Speech articulation□ NO □ YES:

A. **If possible, list three situations in which you have noticed the speech/ problem is worse than usual.**
    a. ____
    b. ____
    c. ____

B. **If possible, list three situations in which you have noticed the speech problem is better than usual.**
    d. ____
    e. ____
    f. ____

Primary Concern:

Primary Therapy Goal: