Your Speech, Language, and Hearing History

The following information helps us tailor therapy to your unique needs. Thank you for taking the time to complete this form.

Today's Date_____

Name _____ Date of birth: _____ Age: _____

Male ☐ Female ☐

Address_____
Street City State Zip

Email_____

Phone_____
Home Work Cell

Have you been evaluated for this before? YES ☐ NO ☐

If yes, where?_____ When? _____

Referred by _____

Reasons for Referral _____

Primary Insurance Name & Member ID Number: _____

Secondary Insurance Name & Member ID Number: _____

Insurance Policy Holder Name: _____

Insurance Policy Holder Date of Birth: _____ Relation to patient: _____

Family

1. Where do you live? With whom?

2. What language(s) do you speak? Which is stronger?

Medical

1. List any past hospitalizations, major surgeries, accidents or illnesses.

2. List any medications you take.

Education

1. What is the highest level of education you earned?

History of Problem

1. Describe your speech or language problem.

2. Do you know what caused the speech problem? If so, what?

3. Has the problem improved or worsened at all?

4. Was the problem sudden or did it develop over time?

5. Does this problem cause any concerns with your family members, co-workers, etc.?

6. Are there any conditions that make the problem better or worse?

7. What strategies have you used in the past to overcome the problem?

8. Have you ever received any professional help from a speech language pathologist, occupational therapist, audiologist, physical therapist, etc. for the problem?

9. Please describe your communication needs.

10. What do you hope to accomplish out of speech therapy?

11. Do you have any eating or swallowing difficulties? If so, explain: