2384 Highway 287 N., Suite 212
Mansfield, TX 76063
sllstx.office@gmail.com

SPEECH LANGUAGE & LEARNING SERVICES
LEARNING TO COMMUNICATE FOR SUCCESS IN LIFE!

Office: 682-400-8132
Fax: 682-400-8235
www.sllstx.com

Patient Information:

Name: Mr. Mrs. Ms._____
Date of Birth:_____Social security #_____
Address:_____
City, State Zip:_____
Home Phone:_____
Cell Phone:_____
Email:_____

Occupation:_____
Business Phone:_____
Employer:_____
Address:_____
City, State Zip:_____
Marital Status:_____
Do you communicate by text? ☐ Yes ☐ No

Persons sharing your home:

Names	Gender	Ages	Relationship

Referral Information:

Referred by: _____ Phone: _____ Fax: _____
Primary Care Provider:_____ Address, City Zip:_____
Phone: _____Fax: _____ Email: _____

Primary Insurance:

Plan:_____ Subscriber:_____ Member ID #:_____ Group #_____
Billing Address:_____ Phone: _____Fax: _____

Secondary Insurance:

Plan:_____ Subscriber:_____ Member ID #:_____ Group #_____
Billing Address:_____ Phone: _____Fax: _____

Primary Language Spoken:_____ Secondary:_____ Others:_____ Do you need an interpreter? ☐ No ☐Yes

Highest level of education you have completed: _____

Describe your speech-language problem: _____

What do you think may have caused the problem? _____
Has the problem changed since it was first noticed? ☐ No ☐ Yes Please describe: _____

Have you seen any other speech-language pathologists? ☐ No ☐ Yes Who? _____
When? _____ Conclusions or suggestions? _____

Specialist visits: (i.e. physicians, ENT/ORL, psychologists, neurologists, dentists, orthodontists, etc.)?
Type of specialists _____ Dates _____ Conclusions/suggestions: _____

Are there any other speech, language, learning, or hearing problems in your family? ☐ No ☐ Yes Relationship: _____
Describe the problem: _____

Describe your level of stress (scale of 1-10, 1 = little to no stress, 10 = constant severe stress.) _____
If your level changes, please indicate levels with situations: _____

How do you or your body respond to stress? _____

What do you do to reduce your stress level? (and how often)? _____

What helps you to relax or relieve your stress? _____

Do you smoke cigarettes? ☐ No ☐ Yes quantity? _____ frequency? _____
Do you consume alcohol? ☐ No ☐ Yes quantity? _____ frequency? _____
Do you consume caffeine? ☐ No ☐ Yes quantity? _____ frequency? _____

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Medical History

Provide the approximate ages at which you suffered the following illnesses and conditions (or frequency of experience):

- ☐ Adenoidectomy_____
- ☐ Allergies_____
- ☐ Asthma_____
- ☐ Chicken Pox _____
- ☐ Croup_____
- ☐ Dizziness_____
- ☐ Ear Drainage_____
- ☐ Swimmers ear_____
- ☐ Ear infections_____
- ☐ Ear drum perforation_____
- ☐ Ear tubes_____
- ☐ Encephalitis_____
- ☐ German Measles_____
- ☐ Headaches_____
- ☐ Head trauma_____
- ☐ Hearing loss_____
- ☐ High fever_____
- ☐ Mastoiditis_____
- ☐ Measles_____
- ☐ Meningitis_____
- ☐ Mumps_____
- ☐ Otosclerosis_____
- ☐ Pneumonia_____
- ☐ Seizures_____
- ☐ Sinusitis_____
- ☐ Tinnitus_____
- ☐ Tonsillectomy_____
- ☐ Tonsillitis_____
- ☐ Other_____

Please list any Allergies (i.e. Food, seasonal, medications, insect bites, etc.): _____

Please list dates of hospitalizations (include diagnoses obtained):_____

Describe any serious accidents or injuries (please include dates): _____

Please list dates of surgeries and reason:_____

List all medications you are currently taking (include dose & reasons for taking them): _____
_____

Describe any negative reactions or side effects you are experiencing, which you believe are related to your medications?_____
_____

Has your hearing been tested? ☐ No ☐ Yes Test Results? _____

Has your vision been tested? ☐ No ☐ Yes Results: ☐ Glasses ☐ Contacts ☐ Other: _____

Describe your level of exposure to noise (i.e. frequency in use of headphones, iPod, construction, power tools): _____
_____

In what ways do you attempt to protect your hearing? _____

Do you have difficulty: ☐ chewing ☐ swallowing food ☐ swallowing liquid ☐ tolerating certain textures ☐ swallowing pills
Please explain: _____

Do you experience choking or a choking sensation while eating or drinking? ☐ No ☐ Yes explain: _____

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

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co-pay, deductible and/or co-insurance. I agree that the information supplied on this form is accurate, current, and complete to the best of my knowledge. I hereby assign Speech Language & Learning Services any insurance or other third-party benefits available for healthcare services provided to me. I understand that ***Speech Language & Learning Services has the right to refuse or accept assignment of such benefits***. If these benefits are not assigned to Speech Language & Learning Services, I agree to immediately upon receipt forward to Speech Language & Learning Services all health insurance and other third-party payments I receive for the services which were rendered to me by Speech Language & Learning Services.

Person completing form (please print):_____
Signature: _____
Relationship to client:_____
Date:_____