

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:

<u>Names</u>	<u>Gender</u>	<u>Ages</u>	<u>Relationship</u>

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? _____

Medical History

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Adenoidectomy _____ | <input type="checkbox"/> Ear tubes _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Encephalitis _____ | <input type="checkbox"/> Otosclerosis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Croup _____ | <input type="checkbox"/> Head trauma _____ | <input type="checkbox"/> Sinusitis _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Hearing loss _____ | <input type="checkbox"/> Tinnitus _____ |
| <input type="checkbox"/> Ear Drainage _____ | <input type="checkbox"/> High fever _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Swimmers ear _____ | <input type="checkbox"/> Mastoiditis _____ | <input type="checkbox"/> Tonsillitis _____ |
| <input type="checkbox"/> Ear infections _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ear drum perforation _____ | <input type="checkbox"/> Meningitis _____ | |

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: _____