



# ADULT SPEECH PATIENT REGISTRATION

## GENERAL INFORMATION

TODAY'S DATE	DATE OF BIRTH	FEMALE OR MALE	SOCIAL SECURITY NUMBER
PATIENT NAME (Last, First, Middle Initial)			
STREET ADDRESS		CITY	STATE ZIP
HOME PHONE NUMBER		CELL PHONE NUMBER:	
NATIVE LANGUAGE	OTHER LANGUAGES SPOKEN	EMAIL ADDRESS	OCCUPATION
NAME OF PERSON FILLING OUT QUESTIONNAIRE		RELATIONSHIP TO CLIENT, IF OTHER THAN CLIENT	

**\*\*If you have received HELP in the HOME (bathing, aide help, therapy, nurse visit) in the past three months please stop here, and speak to the Receptionist.**

Receptionist call (866) 211-5708 for Medicare patients \_\_\_\_\_ (initials)

How did you hear about us? Check One: Doctor \_\_\_\_\_ Advertisement/Radio \_\_\_\_\_ Internet \_\_\_\_\_  
 Friend/Relative (who?) \_\_\_\_\_ Employee (who?) \_\_\_\_\_ Other \_\_\_\_\_

WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?  Myself  (Other) or Responsible Party \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Who is your Specialty Physician? \_\_\_\_\_ Other Physician: \_\_\_\_\_

Referred By: \_\_\_\_\_  
 (Name) (Profession)

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY:
POLICY NUMBER:	POLICY NUMBER:

## POLICY HOLDER'S INFORMATION

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE ZIP	HOME PHONE (if different from above)
IS THE POLICY HOLDER CURRENTLY EMPLOYED BY THE EMPLOYER PROVIDING INSURANCE? YES NO N/A EMPLOYER NAME: EMPLOYER PHONE NUMBER:		

## EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	PHONE #
NAME	RELATIONSHIP TO PATIENT	PHONE #

What is the highest grade, diploma or degree you earned? \_\_\_\_\_

Please explain the problem for which you are being seen today: \_\_\_\_\_

How long have you been experiencing this/these condition(s)? \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

Did it begin suddenly? \_\_\_\_\_ Gradually? \_\_\_\_\_

What do you think may have caused the problem? \_\_\_\_\_

Has the problem changed since it was first noticed? \_\_\_ If yes, describe: \_\_\_\_\_

Has your voice changed in the past year? Yes  No

If so, check all that apply:

- Hoarse  Quieter  
 Whispery/Breathy  Other: \_\_\_\_\_

Did the changes in your voice start gradually/suddenly? (Circle one)

What was the date of onset of your voice change? \_\_\_\_\_

Has your speech changed in the past year? Yes  No

Did the changes in your speech start gradually/suddenly? (Circle one)

What was the date of onset of your speech change? \_\_\_\_\_

**Auditory History:**

Do you have a hearing problem? (circle) Yes No If yes, describe: \_\_\_\_\_

Which ear is affected? (circle) Right Left Both

When did you first notice your hearing loss? \_\_\_\_\_

Did it begin suddenly? \_\_\_\_\_ Gradually? \_\_\_\_\_

Has your hearing loss gradually gotten worse? (circle) Yes No

What do you think caused your hearing loss? \_\_\_\_\_

Do you ever experience dizziness, balance problems, or spinning sensation? (circle) Yes No

If yes, please describe fully: \_\_\_\_\_

**Medical History:**

Have you been hospitalized within the past five years? \_\_\_ Yes \_\_\_ No If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

List any major surgeries and the approximate dates: \_\_\_\_\_

\_\_\_\_\_

Have you seen any other speech-language pathologists? Who and when? What were their conclusions or suggestions? \_\_\_\_\_

\_\_\_\_\_

Have you seen any other specialists (physician, psychologists, neurologists, etc.?) If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions. \_\_\_\_\_

\_\_\_\_\_

Have you ever been treated by an ENT (Ear, Nose & Throat) physician in the past? YES / NO

If yes, for what condition(s)? \_\_\_\_\_

List all medications you are taking: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Are you a singer? YES / NO Have you received formal voice training in the past? YES / NO

Do you smoke? YES / NO If yes, how much? \_\_\_\_\_

Do you drink alcohol? YES / NO If yes, how much per week? \_\_\_\_\_

How much caffeine do you drink per day? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

**Frequency of pain** interfering with patient's activity or movement:

\_\_\_ 0-No pain or pain does not interfere with activity or movement

\_\_\_ 1-Less often than daily

\_\_\_ 2-Daily but not constantly

\_\_\_ 3-All of the time

**Do you currently experience or have history of any of the following?** (Please circle any that apply.)

- |                           |                  |                                   |
|---------------------------|------------------|-----------------------------------|
| High blood pressure       | Dry mouth        | Frequent throat clearing          |
| Low blood pressure        | Dry throat       | Chronic cough                     |
| Shortness of breath       | Stroke           | Frequent bronchitis               |
| Frequent laryngitis       | Allergies        | Feeling of a 'lump' in throat     |
| Hiatal hernia             | TMJ              | Fatigue after speaking            |
| Frequent sore throats     | Hearing loss     | Loss of voice in morning          |
| Difficulty getting volume | Throat tightness | Loss of voice at night            |
| Voice change              | Stomach ulcers   | Heartburn/gastroesophageal reflux |

Gastrointestinal conditions-explain ( \_\_\_\_\_ )

Cancer-explain ( \_\_\_\_\_ )

Upper respiratory conditions-explain ( \_\_\_\_\_ )

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

\_\_\_\_\_

**Dysphagia Case History**

Do you have any problems with swallowing?     Yes     No

If so, when did the problem start? \_\_\_\_\_

Briefly describe the difficulty: \_\_\_\_\_

Have you had any previous swallowing or throat problems?     Yes     No

If so, please describe: \_\_\_\_\_

Did the start of your swallowing problem relate to other medical problems you have?     Yes     No

If so, please describe: \_\_\_\_\_

When you eat or drink, do you have episodes of coughing?     Yes     No

When you eat or drink, do you have episodes of choking?     Yes     No

Do you wear dentures when you eat?     Yes     No

Does food or drink ever "go down the wrong way"?     Yes     No

Does your food generally require special preparation before you can eat it?     Yes     No

If so, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you avoid certain foods because they are difficult to swallow?  Yes  No  
If so, please list examples: \_\_\_\_\_

Do you find food in your mouth after you swallow?  Yes  No

Do you have difficulty keeping food or drink in your mouth?  Yes  No

Do liquids ever come back through your nose when you swallow them?  Yes  No

Do you ever feel that food gets 'stuck' in your throat?  Yes  No

If so, describe where it feels stuck: \_\_\_\_\_

Do you regularly wake up at night coughing?  Yes  No

Do you often wake up with a bad/sour taste in your mouth?  Yes  No

Is your swallowing problem intermittent/constant? (Circle one)

Has your swallowing problem changed over time?  Yes  No

If so, please describe: \_\_\_\_\_

Are there any factors that make your swallowing problem worse?  Yes  No

If so, please describe: \_\_\_\_\_

Do you have more difficulty swallowing when in any certain position?  Yes  No

If so, please describe: \_\_\_\_\_

Have you had pneumonia recently?  Yes  No

If so, when? \_\_\_\_\_