New Patient Information:

Name: _______________________________ M ___ F ___

Today's Date: ________________

Parent or Guardian name (if patient is under 18):
____

Patient Date of Birth: ___________________

Social Security #:________________________

Patient Address: ____

____

Home Phone: __________________________

Cell Phone:____________________________

Email* ____

Primary Insurance:
Name of Insured: ____________________________

Date of Birth: ______________________

Social Security #: _______________________
Relationship to Patient (e.g., parent, spouse, or self): ___________

Name of Insurance Company:
____

Policy Number: ______________________________

Customer Service #: ___________________

Group Number: _____________________________

Group Name/ID: _______________________

Claims Address: ____

Secondary/Additional Insurance:
Name of Insured: ______________________________

Date of Birth: _______________________

Social Security #: ________________________

Relationship to Patient: ____________________

Name of Insurance Company:
____

Policy Number: ______________________________

Customer Service #: ___________________

Group Number: _____________________________

Group Name/ID: _______________________

Claims Address: ____

Health Information:
Reason for contacting? _______________________________________

____

____

Current Medications (specific names or types of meds e.g., heartburn medication):

____

____

____

Primary Care Physician: ________________________

Phone: __________________________

Address: ____________________________________

Fax: ____________________________

City/State/Zip: ____

Specialty Care Physicians (i.e. neurologist, ENT, pulmonologist):
Name: ________________________________
Phone number: ________________________
Name: ________________________________
Phone number: ________________________
Name:
____
Phone number: ________________________
Name: ________________________________
Phone number: ________________________

Recent Hospitalizations? Yes No If Yes, please list dates, location, and reason for admission:
____

Recent Pneumonia? Yes No If Yes, when? _____________________________________
Recent Injury or Surgery?

____

Do you wear glasses/contacts? ______________
Hearing aid? ________________________

Please list any other assistive devices/implants (i.e., vagus nerve stimulator, pacemaker, etc): ____

____

Medical history: please check all that apply. Please provide the dates where applicable

- ☐ Heart attack
- ☐ Heart troubles
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Chronic laryngitis
- ☐ Acid reflux
- ☐ Ear infections
- ☐ Meningitis
- ☐ Seizures
- ☐ Head injury
- ☐ Neurological conditions
- ☐ Allergies
- ☐ Cancer
- ☐ Head/neck cancer
- ☐ Shingles
- ☐ Bronchitis
- ☐ COPD
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Arthritis
- ☐ Hearing loss
- ☐ Cerebral palsy
- ☐ Intellectual deficits, MR
- ☐ Cleft palate
- ☐ Chronic colds
- ☐ Facial nerve palsy
- ☐ Emotional or psychological issues
- ☐ Multiple sclerosis
- ☐ Huntington's or Parkinson's Disease
- ☐ Voice issues or changes
- ☐ Vocal polyps or nodules

What is your current state of health?

- ☐ Excellent
- ☐ Average-fair
- ☐ Poor

Do you use any of the following assistance devices?

- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Other
- ☐ None

Are you able to climb stairs: _____ Yes _____ No

SPEECH-LANGUAGE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

Are there any other difficulties besides what is listed above?

When was this problem first noticed?
Did the problem begin suddenly or develop over time?

Have you been seen by any other rehabilitation professionals?

- ☐ **Speech therapy**: where: __________ when: ___________
- ☐ **Physical Therapy**: where: __________ when: ___________
- ☐ **Occupational Therapy**: where: __________ when: ___________
- ☐ **Other**:

Does this speech-language difficulty impact your ability to function in daily life?

How or where does the speech-language difficulty impact you the most?

Describe your daily communication needs:

What do you hope to get out of speech-language therapy?

1. Marital Status:
   - ☐ Single
   - ☐ Married
   - ☐ Divorced
   - ☐ Widowed

2. Spouse or partner's name: ___________________________________
3. Children:

Names	Ages

4. Occupation:
____

Do you currently work? _____YES _____ NO

____
Patient signature Date