

**ADULT SPEECH-LANGUAGE PATHOLOGY
HISTORY FORM**

Name: _____

Date of Birth: _____

 Person completing form: Patient Spouse Parent/Guardian Other- Name _____

Address: _____

Telephone: (home) _____ (work) _____ (cell) _____

Email: _____

Physician Name: _____ Physician Phone: _____

Referred by: _____

Reason for evaluation: _____

 Insurance: _____ Referral Needed: yes no

Policy Number: _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers

Name	Relationship to patient	Address	Phone	Fax
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name	Relationship to patient	Address	Phone	Fax
_____	_____	_____	_____	_____

I authorize the Department to disclose healthcare information to names above. Valid for one year.

 Signature of Patient Parent/Guardian _____ Date: _____

Printed name of Parent/Guardian: _____

Past Medical History

ADD/ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV Positive	<input type="checkbox"/> YES <input type="checkbox"/> NO
AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hormonal Changes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	Laryngitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Learning Disability	<input type="checkbox"/> YES <input type="checkbox"/> NO
Back Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mental Retardation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Physical Limitations	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cerebral Palsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pneumonia/Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dementia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Respiratory Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shortness of breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ear Infections	<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gastric Reflux	<input type="checkbox"/> YES <input type="checkbox"/> NO	Speech/Lang Impairment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Head Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke (CVA/TIA)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing Loss	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swallowing Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tracheostomy tube	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hypertension	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
High fevers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Visual Impairment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Voice Impairment	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ventilator Dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO

Speech Pathologist's notes: _____

ADULT SPEECH-LANGUAGE PATHOLOGY HISTORY FORM (Page 2 of 2) Name: _____

Other Medical History:

Please list any surgeries/medications (and reason for medication):

Significant Family medical history: _____

Family and Social History:

Occupation: _____ Student Unemployed Retired
Education: College High School Last year completed: _____
Marital Status: Single Married Divorced Widowed
Children Yes NO Grandchildren YES NO
Members of Household: _____
Tobacco use: YES NO # of years _____ Packs per day: _____
Discontinued date: __/__/____
Alcohol intake: YES NO # of drinks per week _____
Do you have a substance dependency? YES NO
If yes, please explain: _____

Have you ever been examined or treated by the following?

	<input type="checkbox"/> YES <input type="checkbox"/> NO	Name/Findings
Ear Nose and Throat Specialist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Eye Specialist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Neurologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Psychiatrist/Psychologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Speech/Language Pathologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Neuropsychologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Audiologist (Hearing Test)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Physical or Occupational Therapist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

Any other information that you feel would be important for us to know: _____

Speech Pathologist's notes: _____

Speech Pathologist: _____
Signature ID # Date Time