CHOOSE THE HOME TEAM CYPRESS CREEK THERAPY

Adult Speech Therapy Patient Questionnaire

GENERAL INFORMATION

Patient Name: _____Date of Birth_____Age:_____

Referral Source_____Primary Care Physician_____

Children (Include names, gender & ages) _____

_____

Who lives in the home? _____

_____

What languages do you speak? If more than one, which is your dominant language?
☐ English ☐ Other _____

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

_____

Current Employment Status/Occupation_____

Goals of returning to work (if applicable) _____

_____

REASON FOR VISIT CHIEF COMPLAINT

Please briefly describe your speech-language problem_____

_____

_____

What do you think may have caused the problem?_____

_____

_____

Has the problem changed since it was first noticed? How?_____

_____

Have you seen any other speech-language specialists? Who and when? What were their conclusions or suggestions? _____

_____

_____

Have you seen any other specialists (Physicians, audiologists, psychologists, neurologists, etc.)? ☐ **Yes** ☐ **No** If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions. _____

_____

_____

_____

Are there any speech, language, or hearing problems in your family? ☐ **Yes** ☐ **No** If Yes, please describe_____

MEDICLAL HISOTRY

Provide the approximate ages at which you suffered the following illnesses and conditions:

☐ Adenoidectomy _____	☐ Encephalitis _____	☐ Meningitis _____
☐ Asthma _____	☐ Epilepsy/Seizures _____	☐ Mumps _____
☐ Chicken Pox _____	☐ Feeding Tube_____	☐ Noise Exposure _____
☐ Cleft Palate/Lip _____	☐ German Measles _____	☐ Otosclerosis _____
☐ Colds _____	☐ Headaches _____	☐ Pneumonia _____
☐ Convulsions _____	☐ Hearing Loss _____	☐ Reflux _____
☐ Croup _____	☐ High Fever _____	☐ Sinusitis _____ ☐ Dizziness _____
☐ Influenza _____	☐ Tinnitus_____	
☐ Draining Ear _____	☐ Mastoiditis _____	☐ Tonsillitis_____
☐ Ear Infections _____	☐ Measles _____	☐ Vision Problems_____

☐ Other(s): _____

Do you currently consume alcohol or use tobacco products? ☐ **Yes** ☐ **No** If Yes, please describe frequency:_____

Please list any medications you are currently taking (include Name, Dosage, Frequency, and Route of
Intake)_____
_____
_____
_____

Are you having any negative reactions to these medications? ☐ **Yes** ☐ **No** If Yes, please describe_____

Do you suffer from any chronic medical conditions? ☐ **Yes** ☐ **No** If Yes, please describe
_____

SURGERIES HOSPITALIZATIONS

Please list any prior surgeries, operations, and hospitalizations with approximate date(s):

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please describe any major accidents _____
_____
_____

ORAL M FEEDI	Do you have any eating or swallowing difficulties? ☐ **Yes** ☐ **No** If Yes, please describe:_____ _____ _____
HEARING VISION	Do you have any hearing difficulties? ☐ **Yes** ☐ **No** If Yes, please describe severity and if aided/unaided:_____ _____ Do you have any vision problems? ☐ **Yes** ☐ **No** If Yes, please describe:_____
ADDITIONAL INFORMATION	Have you learned or used any strategies or techniques to improve your impairment? ☐ **Yes** ☐ **No** If Yes, please describe those you have tried and have found most success with: _____ _____ _____ Please describe your hobbies and involvement in any social or civic groups to which you belong. _____ _____ _____ Please provide any additional information that might be helpful in the evaluation or remediation process. _____ _____ _____ _____ _____ _____ _____

Person completing this form: _____

Relationship to client: _____

Signed: _____Date: _____

*If receiving this form electronically prior to your visit, please remember to bring any previous speech and language evaluation reports or related documentation.