



Advanced Therapy Care

Therapy Services for Children & Adults

New Patient Speech & Language Questionnaire - ADULT

PATIENT INFORMATION

Patient's Last Name:	First:	Initial:	Birthdate:
Marital Status:		Name of Spouse or nearest relative:	

What are your reasons for scheduling this appointment?

Please describe your concerns:

Have you received speech therapy before? Yes No

If yes, when and where?

For how long?

Focus & Results of Treatment?

Have you had any significant health problems in your life? Yes No

If yes, please describe:

What do you hope to gain from today's appointment?

Description of Speech and/or Hearing problem:

Check any of the following which describes your problem

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Often hoarse | <input type="checkbox"/> Lacks Volume | <input type="checkbox"/> Difficult to understand others speech | <input type="checkbox"/> Hesitant |
| <input type="checkbox"/> Voice is high pitched | <input type="checkbox"/> Fast Rate | <input type="checkbox"/> Voice tires easily | |
| <input type="checkbox"/> Low pitched | <input type="checkbox"/> Slow Rate | <input type="checkbox"/> Voice breaks | |
| <input type="checkbox"/> Too loud | <input type="checkbox"/> Sounds Gravelly | <input type="checkbox"/> "Lump in the throat" feeling | |
| <input type="checkbox"/> Mispronunciation | <input type="checkbox"/> Stuttering | <input type="checkbox"/> Difficult to understand when you talk | |

Has anyone ever looked at your vocal cords and/or soft palate? Y / N What did they find?

Have you ever had a modified barium swallow test? Y / N What were the results?

Additional comments:

Do you have a history of any of the following? (check all that apply)

- Seizures and/or convulsions
- Serious head injuries
- Hearing difficulties
- Eye difficulties
- Sinus problems
- Difficulty swallowing
- Frequent colds and/or coughs
- High fevers
- Allergies
- Serious illness
- Sore throats
- Noise exposure

Do you have a history of any of the following?

Major surgery or hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
Psychological/psychiatric treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
Chronic illnesses	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
Major accidents	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
Aggression (biting, hitting, punching, kicking, throwing objects)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?

Background Information

Latest educational institution attended:

What was the highest grade level, diploma, or degree earned?

Did/does your speech/language affect your educational performance? If so how?

Occupation:

Employer:

Does your speech/language affect your career? If so, how?

Please check any of the following that you wear:

- Hearing aid
- Dentures
- Glasses
- Prosthetic device

Please list daily medications taken and for what:

Is there any family history of chronic illness, allergies, speech problems, hearing problems, swallowing problems, or other conditions? Please list all and describe conditions.
