Communication Matters

A Professional Corporation

Speech-Language Pathology

"Enhancing Lives Through Communication"

ADULT INFORMATION FORM

DATE: _____

PATIENT'S FULL NAME:

_____

Last First Middle Nickname

Address:_____

_____

Phone: _____ E-mail: _____

Age:_____ Date of Birth:_____ Sex: M____ F____

Occupation: _____Retired? Yes_____ No ____

Highest level of education completed: _____

Primary language: _____ Other languages: _____

Person completing this form: _____

Referred by: _____

Physician: _____Telephone: ( )_____

Physician's Address:_____

_____

To Whom Shall We Send Reports**?:**_ _____

Description of problem:

Please describe the problem and the reason(s) for requesting an evaluation at this time.

_____

_____

_____

What do you think may have caused the problem?

_____

_____

_____

Has the patient ever received speech therapy? When? Where? From whom?
What results? Please provide copies of any reports.

_____

_____

_____

_____

810 Lawrence Drive #100
Newbury Park, CA 91320

www.communicationmatters.us

(805) 273-3870 Office
(805) 273-3871 Fax

List other agencies, psychologists, audiologists, occupational therapists, physical therapists or physicians who have evaluated/treated the patient.

Name Date(s) Findings/Treatment

_____
_____
_____
_____
_____
_____
_____
_____
_____

HISTORY OF ILLNESS: (please give date of onset and severity if applicable)

Stroke: _____ High fevers: _____
Seizures: _____ Allergies:_____
Diabetes: _____ Physical handicaps: _____
Respiratory problems: _____ Ear/Nose/Throat problems:_____
Learning disabilities: _____ Swallowing problems: _____
Vision problems: _____ Teeth/mouth/tongue problems: _____
Dentures: _____ Head Injury _____
High Blood Pressure:_____ Other:_____
_____

HEARING:

Hearing loss/fluctuations? Describe:_____
Hearing Aids? Right Ear___ Left Ear___
Does the patient seem to hear better at certain times than others? Yes ____ No _____
Does the patient seem to hear better in one ear than the other? Right ____ Left _____
Has the patient's hearing been tested? When? Where?_____
Results of test: _____

HOSPITALIZATIONS:

Reason(s)_____ Date(s)_____
_____
_____
_____

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CURRENT MEDICAL PROBLEMS:

_____

_____

Is the patient currently taking any medication?

_____

If so, what medication, how often, and for what condition?

_____

_____

_____

_____

ACCIDENTS OR INJURIES: (Please describe)

_____

_____

_____

_____

Swallowing Problems?

Have you had a swallow test completed? Yes _____ No

Where, When and by whom?

_____

What recommendations were made? _____

Regular Diet _____ Mechanical Soft/Chopped _____ Puree _____
Thin Liquids _____ Thickened Liquids _____ Consistency?

IS THERE ANYTHING ELSE WE SHOULD KNOW?

_____

_____

_____

_____

_____

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