

Client Information

PATIENT NAME

STREET

CITY STATE ZIP

DATE OF BIRTH SEX

NATIVE LANGUAGE(S)

OTHER LANGUAGES

HOME PHONE

CELL PHONE

E-MAIL

OCCUPATION

EMPLOYER

EDUCATION LEVEL

EMERGENCY CONTACT

RELATIONSHIP

PHONE

Please list any hobbies, activities, special interests you enjoy:

Family Information

SPOUSE'S NAME

OCCUPATION

EMPLOYER

If you have children, what are their names and ages?

If there have been any major changes in the family during the last year, please describe.

Medical History

Please indicate if any of the following applies:

Illness / Disability

Eating/Drinking/Swallowing Difficulties

Reflux

Hearing Difficulties

Visual Difficulties

Insomnia

Seizure Disorder

Allergies

Mental Illness

Drug Abuse

Other

If you checked any box on the proceeding page, please describe: _____

Do you have any physical difficulties or limitations? Please explain: _____

If you have been enrolled in speech, physical, and/or occupational therapy, please give the date(s), location(s), type(s) of therapy, and the results of your treatment (*please list doctor information on the next page*): _____

Have you ever been hospitalized? If so, please give the length, date(s), and reasons for each hospitalization: _____

If you are taking any medications, please list them below with the reason they were prescribed: _____

Current Medical Concerns

Please describe any present memory and/or communication difficulties: _____

Doctor Information

Please provide information regarding all doctors from which you have received diagnoses and/or treatments related to your visit.

DOCTOR TYPE / SPECIALTY

DOCTOR

STREET

CITY STATE ZIP

DOCTOR TYPE / SPECIALTY

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Medical Record Release

The following agreement is completely optional. If you agree, it will help Speech Pathology Services as well as its colleagues work together in providing the best possible care for you

By signing, I hereby authorize Speech Pathology Services, Inc. to release and/or obtain my personal medial records with regards to any of the above doctors.

PRINT NAME

SIGNATURE

DATE

Please describe the first occurrence of your memory and/or communication difficulty: _____

Please describe any occupational, personal, and/or social problems that are a direct result of your memory and/or communication difficulty: _____

Please describe the degree to which your conditions changes (gets better, gets worse): _____

What information do you hope to gain from this evaluation, and what specific questions or difficulties do you wish to address?
