sfs therapies

Adult **History and Background Information** **Past Medical History**	**Name:** ______ **Date:** ______ **D.O.B:** ______

Describe your problem:

When did you first notice your problem? ______

Can you think of any reason or cause for your problem? ______

Has anyone else in your family had a speech or hearing problem? ______

Describe any serious illnesses, accidents, or surgery you have had. (Give age at occurrence and severity.)

Etiologies	**Yes**	**No**	**Additional Information**
Allergies			
Asthma			
Broken Nose			
Bronchitis			
Chronic Colds			
Chronic Laryngitis			
Clef Palate			
Ear Disease			
Hearing Problem			
Heart Trouble			
Hypertension			
Hypothyroidism			
Incoordination of face or tongue Muscles			
Influenza			
Mouth-Breathing			
Numbness			
Paralysis/ Paresis			
Pneumonia			
Sinus Infection			
Tremor/Twitching			
Visual Problem			

Please list any other previous medical history that you feel is important for us to know

Adult
History and Background Information
Past Medical History continued

Name: ______
Date: ______
D.O.B: ______

	Yes	**No**	**How much or How many**
Alcohol consumption			
Cigarette Use			

List all surgical procedures (related or unrelated to the voice problem).

______
______
______

Stroke or Brain Injury

Date of Stroke(s) or head injury ______
Age at time of stroke or head injury: ______

Marital Status:	Yes	No
Single		
Married		
Divorced		
Widowed		

Handedness (before stroke):	Yes	No
Right		
left		
Ambidextrous		

Primary language spoken now: ______
Primary language before stroke: ______
First language learned: ______
Languages spoken other than English: ______
Where did this patient grow up? ______
Where has this patient lived as an adult? ______
Occupation(s) (begin with most recent, include approx. # of years):

Position	**Years**

Adult
History and Background Information
Past Medical History continued

Name: ____________________
Date: ____________________
D.O.B:

Stroke or Brain Injury

If the patient had a stroke, describe the events surrounding the stroke and the nature of the patient's problems soon after the stroke (include communication, body weakness, changes in vision):

Describe the patient's current limitations with regard to communication, vision, and physical impairment:

Do those conditions include: Aphasia Right sided weakness Right sided paralysis? ____________

Seizures: if yes, give date of last seizure: ____________________
Loss of vision Does the patient wear glasses?
Has this patient had a visual examination since the stroke? ____________________
Give name of eye doctor and date of last evaluation: ____________________
Does this patient have a hearing loss? Wear a hearing aid (R or L ear)? ____________

When and where was this patient's hearing last evaluated? ____________________

If the patient was previously enrolled in speech-language therapy, indicate where and the clinician's name(s) (if you recall them): ____________________

Has the patient had a CT or MRI head scan? ____________________
When and where was the most recent scan? ____________________
Please describe Communication Disorder ____________________

PRIOR to this patient's stroke, (or the onset of language impairment) was there a history of any of the following?

Etiologies	Yes	No	Additional Information
Memory Impairment			
Head Injury			
Previous Stroke			
Clinical Depression			
Psychiatric Problems			
Alcohol Abuse/Problems			
Substance Abuse			
Dementia			
Other Neurological Disease			
Other Major Illness			

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Adult
History and Background Information
Past Medical History continued

Name: ______________________
Date: ______________________
D.O.B:

Stroke or Brain Injury

Please provide some family and social information about this patient to help us better understand conversational topics of importance: List important family members, friends, or pets: What are some major accomplishments or highlights of this person's life?

List hobbies or other topics of interest:

What are your expectations of this clinic?

Signature: ______________________ Date: ______________________