Clough Consultants and Speech Therapy, INC

Personal History

Date: _____

Patient's Name: _____ Age:_____ DOB:_____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Work phone: _____

Occupation: _____

Employer: _____ Employer Address: _____

Sex: M F Single_____ Widowed_____ Divorced_____ Married_____ Other_____

Spouse's Name: _____

Children (include name and contact information if caregiver)

_____

_____

_____

Who lives in the home with you? _____

_____

What other languages do you speak besides English? _____

_____

Highest grade, diploma, or degree earned: _____

What are your hobbies and interests? _____

_____

_____

Do you require assistance with any of the following? (Please check off)

Dressing ____ Toileting ____ Money Management/Paying Bills ____ Cooking ____

Transportation/ Driving ____ Keeping track of appointments ____ Eating ____ Telling Time _____

Showering/ Personal Hygiene ____ Moving/walking from place to place ____ Making phone calls ____
Grocery Shopping ____ Housekeeping _____ Other _____

Referral Information

Existing Diagnosis: _____

Referred by: _____

How did you hear about us? _____

Reason for Referral: _____

_____

_____

Patient's Primary Physician: _____

Physician's Company: _____

Physician Phone: _____ Fax: _____

Concerns

Describe the problem for which you are referred and concerns related to:

_____

_____

_____

What do you think may have caused the problem and when did you first notice the problem?

_____

_____

_____

_____

Has the problem changed since you first noticed it? If so explain. _____

_____

_____

Have you seen any other speech-language pathologists this past year? If so list who, when and results. Please bring copies of treatment if applicable:

_____

_____

_____

_____

Have you see any other specialists (physicians, psychologists, neurologists, physical therapist, occupational therapist, etc.) please list?

_____

_____

_____

_____

Medical History

Please check any of the following illnesses and conditions you may have had and approximate date of occurrence:

Hearing Loss: _____ COPD:_____asthma: _____ CHF:_____
Dementia: _____ Seizures:_____Diabetes:_____ Stroke:_____
Traumatic Brain Injury:_____ Encephalopathy:_____ GI bleed:_____
Oxygen Dependent: _____ Vocal Fold Paralysis: _____ short bowel syndrome:_____
Parkinson's: _____ ALS: _____ Alzheimer's:_____ Autism:_____

Do you have any other medical diagnoses? Please list:

_____
_____
_____

Do you have any eating or swallowing difficulties? If yes, describe any modified diets, types of food difficult for chewing or swallowing, dentation (dentures, missing teeth, partials):

_____
_____
_____

Have you had a modified barium swallow study or endoscope performed? If yes, provide location and date: _____
_____

List medications you are taking: _____
_____
_____

List major surgeries, operations, or hospitalizations and dates they occurred:

_____
_____
_____
_____

List any major accidents and when they occurred:

_____
_____
_____

Please provide any additional information related to speech, memory, social skills, swallowing and communication concerns:

_____
_____
_____
_____
_____
_____

Please complete this form along with any copies of any previous evaluations, reports and medical information you would like for consideration prior to evaluation.