ACHIEVE SPEECH AND LANGUAGE
19100 W. Lake Houston Pkwy., Ste #104 · Humble, TX 77346
Ph: (281) 812-9519 · Fax: (281) 812-5719 · Email: Info@AchieveSLS.com

Name of Person Completing this Form: _____ Relationship to Client:_____

Personal Information

Patient Name: _____ Birth Date: _____ ❑ Male ❑ Female
First MI Last

Patient Address: _____ Phone #: _____
Street City Zip

Email Address: _____

Primary Physician: _____ Phone #:_____

Emergency Contact: _____ Relationship: _____

Phone #: _____

Children: *name/age* _____
Who lives in your home? _____

What is the primary language spoken in your home? _____
What other language(s) do you speak? _____

Work/Social History

Highest grade completed: _____ Degree(s): _____

Work History: ❑ Currently Employed ❑ Retired- date_____ ❑Furlough- date_____
Occupation: _____ Place of Employment: _____
Job Duties: _____

Household Responsibilities: *check all that apply*
❑computer tasks ❑balancing checkbook ❑grocery shopping ❑cooking ❑cleaning ❑child care ❑yard work ❑household repairs ❑laundry ❑ driving ❑other: _____

List any specific hobbies, interests, or social activities: _____

Have activities been negatively impacted (work, hobbies, or other)? ❑ No ❑ Yes: what and how?

_____

_____

Have there been any significant changes in your environment? (family illness, deaths, divorce, moves, etc.)

_____

_____

Health History

What are your speech and language concerns? _____

_____

_____

When did symptoms first begin?_____ What caused the problem?_____

Have symptoms: ❑worsened, ❑improved, ❑remained the same?

Have you seen any other speech-language specialists? ❑ No ❑ Yes, dates:_____

Effects of previous treatment_____

Do you have any allergies? *latex, food, seasonal, drug, etc.* ❑ No ❑ Yes:_____

Have you experienced any of the following? *Check all that apply*

❑ Acid Reflux	❑ Cerebral Palsy	❑ Headaches	❑ Operations / Surgery
❑ ADD / ADHD	❑ CVA / Stroke	❑ Hearing Loss	❑ Serious Accident
❑ Asthma / COPD	❑ Epilepsy / Seizures	❑ Hospitalization	❑ Serious Illness
❑ Cancer	❑ Fainting	❑ Intubation/Tracheotomy	❑ Under- / Overweight
❑ Cardiovascular Disease	❑ Head Injury	❑ Motor Tics (Jerking)	❑ Vision Loss

Additional Information: *dates, types, duration, treatment*

_____

_____

Do you have concerns with your hearing or vision? ❑ No ❑ Yes – If *yes*:

Do you: - wear glasses? ❑ No ❑ Yes - hearing aid(s)? ❑ No ❑ Yes

Current medications: (list additional medications on back of page)

Name of Medication(s): *Reason:* *Dates:* *Noted Side Effects:*

_____

_____

_____

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc)? ❑ No ❑ Yes

If *yes*, please complete:

Specialist Type: *Dates:* *Conclusions:* Please provide copies of reports if possible

_____

_____

_____

Please use back of page for additional information and comments.

Vocal History

If concerns relate to voice, please complete the following:

Check all symptoms that apply:

❑ breathiness/hoarseness ❑ frequent coughing ❑ pain in throat ❑ strained/loss of voice
❑ breathing problems ❑ heartburn/reflux ❑ seasonal allergies ❑ tickling in throat

Have you been referred to an ENT? ❑ No ❑ Yes: date:_____ conclusions: _____

Daily water intake: ❑ < 2 glasses (16oz) ❑ 3-4 glasses (17-32oz) ❑ 5-7 glasses (33-56oz) ❑ 8+ (>64oz)

Daily caffeine intake in ounces (coffee, tea, soda, other): _____

Daily alcohol servings: ❑ 0 ❑ 1 ❑ 2 ❑ 3+ Type_____

Smoking history: ❑Nonsmoker, ❑Former Smoker (quit date:_____),❑Current Smoker, ❑Secondhand Exposure

For current and former smokers- Type smoked: ❑cigarettes, ❑pipe, ❑cigar, ❑chewing tobacco, ❑recreational drugs

Number per day____; Packs per day ___

Is a special or restricted diet used? ❑ No ❑ Yes: _____

Would the diet promote reflux (ex: spicy foods, high fat foods, caffeine)? ❑ No ❑ Yes

In what ways is the voice typically used?:

❑cheering at games, ❑professional speaking, ❑talking over noise, ❑other_____

Frequency and duration: _____

Impact of voice problems on daily activities: _____

In what ways is stress managed? (ex: exercise, medication, counseling, meditation)_____

_____