Chris Byers, MA, CCC-SLP
Speech-Language Pathologist

Phone: (818) 419-1123 **www.ChrisByers.net**

DATE: _______________

Patient's Name:____

Address:____

____

Home Phone: ______________ Cell 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:____

____

Description of problem:
Please describe the reason(s) for requesting an evaluation/therapy 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.

____

____

____

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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: _______________________
Seizures: _____________________
Diabetes: _____________________
Respiratory problems: __________
Learning disabilities: ___________
Vision problems: ______________
Dentures: _____________________
High Blood Pressure:___________
High fevers: ____________________________
Allergies:________________________________
Physical handicaps: ______________________
Ear/Nose/Throat problems:_________________
Swallowing problems: ____________________
Teeth/mouth/tongue problems: _____________
Head Injury _____________________________
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)

____

____

____

____

<u>Swallowing Problems?</u>
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?

____

____

____

____

____