Web: www.Chandlerspeech.com
Phone: 678.288.9770 + Fax: 678.288.9774
4319 South Lee St. Suite 200 Buford GA 30518

Patient History – Adult

Name: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work or Other Phone: _____

E-mail: _____

Race/Ethnicity (select one or more):

American Indian/Alaskan Indian
Asian
Black/African American
Hispanic/Latino
Native Hawaiian or Other Pacific Islander
White
Unknown

Marital Status:
Married Single Widowed

Caregiver:

Do you have any children? Yes No

If so, is your child your caregiver? Yes No

Do you have multiple caregivers? Yes No

Emergency Contact:

Name: _____

Phone Number: _____

Is this number for Home Cell Work

Relationship to Patient: _____

Referral Source:

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Doctor School Counselor/Therapist Friend Self Other

Insurance Information:

Reason for Visit Today

_____

_____

_____

Have you received speech-language pathology services before? Yes No

If yes, when? _____

Where? _____

Have you received any other therapy services before (rehab, OT, PT)? Yes No

If yes, when? _____

Where? _____

Medical History:

List illnesses, surgeries, injuries, or medical problems. Please list date and the cause of injury, if any.

_____

_____

Have you experienced any muscle weakness? If so describe this experience:

_____

___

Have you experienced any hearing/vision problems due to this injury? Yes No

If yes, how so?

_____

_

List medications taken on a regular basis:

_____

_____

List known allergies:

_____

_____

Have you had problems with or changes in (check all that apply):

Hearing:

Wear hearing aid(s)? Yes No

Had hearing test? Yes No

If yes, when? _____

Vision:

Wear glasses? Yes No

Wear corrective lenses? Yes No

Had vision screened? Yes No

If yes, when? _____

Teeth:

Wear dentures? Yes No

Breathing:

Swallowing:

Education and Work History

Last grade completed: ___ _____

Occupation before onset: __ _____

Currently working? Yes No

Hobbies/Special Interests: __

_____

_____

_

Did you enjoy reading/writing before onset?

Preferred use of hand: Right Left Both

Language(s) Spoken

Is English your primary language? Yes No

If no, is an interpreter needed? Yes No

If no, what language(s) is/are spoken at home:

_____

If no, what language(s) is/are spoken in your workplace/community:

_____

Communication and Language

Please describe your speech after onset? (Respond in one words, short phrases, repeats others, etc.)

_____

_____

Has your speech changed after onset? Yes No

If yes, how did it change?

_____

How do you currently communicate with others? (Verbally, use of gestures, writing, use of AAC, etc.)

_____

How well can you follow directions, following along in conversations, remember items, etc.?

_____

_____

What are your biggest difficulties?

_____

_____

How do you solve/react to these difficulties? (Removal, anxiety, frustration, etc.)

_____

When are you most frustrated with your communication?

_____

_____

Additional Information

What is your current daily routine?

Describe your personality before and after onset?

Were there any changes in mood, personality, self-care, etc?

Tell us about your goals and expectations for therapy:

Is there anything else you'd like for us to know about you?

I am granting permission for Chandler Speech and Language Services to evaluation and provide treatment recommendations as clinically necessary.

Attendance is a critical factor with regard to therapy services.

I understand that if I need to cancel my appointment I must do so within 12 hours of the appointment time. If I fail to do so, Chandler Speech and Language has the right to charge a no-show fee of $50.

If I miss 3 consecutive sessions of therapy, Chandler Speech and Language has the right to place services on hold until scheduling may be resolved.

My signature indicates that, to the best of knowledge, all information provided above is accurate and current. My signature indicates I am in agreement with all policies presented above. I acknowledge that it is my responsibility that if my insurance changes at any time or fails to cover any services, I may be responsible for any remaining balance.

Patient or Parent/Guardian Signature

Relationship to Patient

Date