MERCYHEALTH

Mercy-Tiffin Rehabilitation and Therapy
Adult Speech Rehab Services Patient History Questionnaire

In order for us to fully address all aspects of your problem, the following information is needed. Please take time to complete this form. Feel free to ask for assistance or clarification. Thank you!

Name:_____ Date:_____

PERSONAL

Do you speak and read English easily? ☐ Yes ☐ No

If no, what language do you use daily?_____

Are you 65 years of age or older? ☐ Yes ☐ No

Have you fallen in the last year? ☐ Yes ☐ No

(Therapist note: a YES to either question requires a Fall Risk Assessment)

HISTORY OF CURRENT COMPLAINT

1. What is the reason you are here for therapy? _____

_____

2. How did this happen? (accident, etc.)_____

_____

3. When did it start? Date:_____
4. Have you had this problem before? ☐ Yes ☐ No
5. Have you had therapy for this problem before? ☐ Yes ☐ No
   If yes, when?_____ At what facility?_____ How long?_____

6.Has your doctor run any of the following tests for your current problem?

☐ X-Ray ☐ MRI ☐ CT ☐ EMG ☐ Vascular Studies ☐ Other:_____

7.Are you currently having any pain or have you had pain in the recent past? ☐ Yes ☐ No

8. What do you hope to get out of speech-language therapy?_____

_____

_____

_____

MEDICAL HISTORY

1. Have you had, or do you now have, any of the following listed conditions? (Check all that apply)

☐ High Blood Pressure	☐ Heart Problems	☐ Pacemaker
☐ Panic Attacks	☐ Stroke	☐ Diabetes
☐ Gland Problems (Thyroid)	☐ Arthritis	☐ Anxiety

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☐ Cancer ☐ Lung Disease ☐ Circulation Problems

If Cancer: Type and Type of Treatment_____

☐ Vision Problems ☐ Hearing Problems ☐ Stomach Problems (ulcers, etc)
☐ Seizures ☐ Blood Disorder/Sickle Cell ☐ Depression
☐ Kidney/Bladder Control issues ☐ Asthma ☐ Emphysema
☐ Current Smoker ☐ Breathing Problems ☐ Pneumonia
☐ Parkinson's Disease ☐ Huntington's Disease ☐ Acid Reflux
☐ Vocal Polyups/Nodules ☐ Head Injury/Traumatic Brain Injury
☐ Drink Alcohol: ☐ None ☐ Occasionally ☐ Often
Other Not Listed (please explain):_____

2. Please list type and year of any surgeries you have had:_____

_____
_____
_____

3. Please list any medication or herbal remedies you are currently taking:_____

_____
_____
_____

4. Are you allergic to:
Cortisone/Dexamethasone ☐ Yes ☐ No Bee Stings ☐ Yes ☐ No
Lidocaine/Novacaine ☐ Yes ☐ No Latex ☐ Yes ☐ No
Pool Chemicals ☐ Yes ☐ No
Please list any other allergies:_____

5. Is there any chance you might be pregnant? ☐ Yes ☐ No
6. Are there any additional issues or concerns that you would like your therapist to be aware of?

_____
_____

Next Doctor's Appointment:_____
Please Keep us updates on the date of your next doctor's appointment throughout your treatment program.

Signature:_____ Date:_____

SPEECH-LANGUAGE HISTORY

SYMPTOM	NEVER	SOMETIMES	FREQUENTLY
Difficulty Swallowing	☐	☐	☐

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Difficulty Expressing thoughts	☐	☐	☐
Difficulty being understood by others	☐	☐	☐
Difficulty understanding what others are saying to you	☐	☐	☐
Orientation/Memory	☐	☐	☐
Problem Solving	☐	☐	☐
Focusing/attention	☐	☐	☐
Reading/writing	☐	☐	☐
Finding Words	☐	☐	☐
Maintaining topic in Conversation	☐	☐	☐
Fluent Speech (stuttering)	☐	☐	☐
Following Directions	☐	☐	☐
Oral Motor Weakness (tongue, lips, etc)	☐	☐	☐
Voice Difficulties	☐	☐	☐

Are there any other difficulties besides what is listed above?_____
_____
_____

Did the problem begin suddenly or develop over time?_____
_____
_____

Does this speech-language difficulty impact your ability to function in daily life? How?_____
_____
_____

Describe your daily communication needs:_____
_____