Patient Information Form

Patient Information

Patient Name: _____ Date of Birth: ___/___/_____ Age: _____
Last First MI mo day year

Gender: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referred by: _____ Primary Care Physician: _____

Other specialists involved in care: _____

Primary reason(s) for today's visit: _____

_____

Insurance Information

Person Responsible for Account: _____
Last First MI

Primary Insurance Company:_____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Group Number: _____ ID Number: _____

Secondary Insurance Company:_____

Subscriber's Name: _____ Subscriber's Date of Birth:_____

Group Number: _____ ID Number:_____

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: _____ Date: _____

Patient Name: _____
Date of Birth: _____

ESHC Evergreen Speech & Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Case History Update Form

Name: _____ Age: _____Today's Date: _____

1. What is the principle concern regarding your communication skills?

2. What are the new concerns since your discharge from therapy?

3. Please explain any changes in your medical status since the previous evaluation.

4. Please explain any changes in your occupational/ academic status since the previous evaluation.

5. Have you participated in any specialized treatment (i.e. Occupational Therapy, Physical Therapy, Counseling, etc.) since the previous evaluation? Please explain.

6. What do you hope to gain from this re-evaluation?

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Systems History

Ears, Nose, Throat, and Mouth

Ears
- ☐ Hearing loss
- ☐ Consistent ear infections
- ☐ Placement of PE tubes (when? _____)
- ☐ Skin tags or pits near the ears
- ☐ Struggle with hearing in noisy places
- ☐ No concern

Nose
- ☐ Chronic congestion
- ☐ Frequent sinus infections
- ☐ Trouble breathing through nose
- ☐ No concern

Throat
- ☐ Painful swallowing
- ☐ Pain or discomfort after of talking
- ☐ Hoarseness
- ☐ Frequent throat clearing
- ☐ Feeling of something 'stuck' in throat
- ☐ No concern

Mouth
- ☐ Difficulty chewing
- ☐ Coughing frequently while eating
- ☐ Constant dry mouth
- ☐ No concern
- ☐ Other: _____

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Shortness of breath with exertion
- ☐ No concern
- ☐ Other: _____

Psychiatric
- ☐ Anxiety or stress
- ☐ Depression
- ☐ Sleep problems
- ☐ No concern
- ☐ Other; _____

Vision

Acuity
- ☐ Nearsighted
- ☐ Farsighted
- ☐ Astigmatism
- ☐ No concern

Visual Processing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Difficulty tracking
- ☐ Objects moving while trying to focus
- ☐ Dyslexia
- ☐ No concern
- ☐ Other: _____

Respiratory
- ☐ Asthma
- ☐ Apnea/ Dyspnea
- ☐ Shortness of breath
- ☐ Frequent episodes of pneumonia, bronchitis, or other infections
- ☐ Trouble achieving adequate breath support
- ☐ No concern
- ☐ Other: _____

Neurological
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Weakness
- ☐ Tremors
- ☐ Seizures
- ☐ Memory loss
- ☐ Poor attention
- ☐ History or brain injury or concussions
- ☐ No concern
- ☐ Other: _____

Skin
- ☐ Rashes
- ☐ Acne
- ☐ Eczema
- ☐ No concern
- ☐ Other: _____

Musculoskeletal
- ☐ Muscle/ joint pain
- ☐ Back pain
- ☐ Scoliosis
- ☐ No concern
- ☐ Other: _____

Gastrointestinal/ Genitourinary
- ☐ Heartburn or reflux
- ☐ Frequent nausea/ vomiting/ diarrhea
- ☐ Constipation
- ☐ Nighttime urination
- ☐ Kidney problems
- ☐ No concern
- ☐ Other: _____

Allergies
- ☐ Seasonal allergies
- ☐ Food allergies

Details: _____
- ☐ Medication allergies

Details: _____
- ☐ None
- ☐ Other: _____

Motor Development

Fine Motor
- ☐ Poor handwriting
- ☐ Trouble grasping small objects
- ☐ Trouble opening or closing screw-lid containers
- ☐ Trouble coordinating vision with hand movements (i.e. putting a puzzle together)
- ☐ No concern

Gross Motor
- ☐ Trouble balancing
- ☐ Falls often
- ☐ Easily trips over objects
- ☐ No concern
- ☐ Other: _____

Previous Diagnoses

Please check all previous diagnoses.
- ☐ ADD
- ☐ ADHD
- ☐ Autism
- ☐ Asperger's Syndrome
- ☐ Cerebral Palsy
- ☐ Downs Syndrome
- ☐ Mental Retardation
- ☐ OCD
- ☐ No concern
- ☐ Other: _____