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

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: ______________

Kirkland Office ◆ 12333 NE 130th Lane, #430 ◆ Kirkland, WA 98034 ◆ 425.899.5050 Fax - 425.899.5054
Bellevue Office ◆ 1800 116th Ave NE, #103 ◆ Bellevue, WA 98004 ◆ 425.454.1883 Fax - 425.454.2036
Redmond Office ◆ 8301 161st Ave NE, #208 ◆ Redmond, WA 98052 ◆ 425.882.4347 Fax - 425.882.0043

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Adult Speech History Form

Patient Name: ____

Date of Birth:__________________________________ Today's Date:____________________________

Please list those living in your home and their relationship to you: ______________________________

____

Primary Concern(s) of today's visit: ____

____

Health History

YES NO

☐ ☐ Any illnesses, injuries, or complications in childhood?
If yes, describe (including date and treatment): ____________________________________
Please list any current or past conditions: ____
____

☐ ☐ Are you taking any medications?
If yes, please list dosage and frequency: ____
____

☐ ☐ Is there a family history of speech, language, or learning problems?
If yes, please explain (include syndromes, dysfluencies/ stuttering, speech/ languages impairments): ____

☐ ☐ Has your vision been tested?
If yes, please indicate results: ____

☐ ☐ Do you have any allergies?
If yes, please describe: ____

Vocation

YES NO

☐ ☐ Are you currently employed?
If yes, what is your occupation? ____

☐ ☐ Are you currently a student?
If yes, where do you attend school? ____
Please describe how often you are required to speak at work and/ or school (i.e. for presentations, meetings, etc.): ____
____

Social History

What language(s) is/ are spoken in your home?____

What kinds of social activities do you participate in (i.e. Church, book groups, clubs, etc.)? _______________

____

Speech and Language

YES NO

☐ ☐ Do you have any difficulties understanding others?
If yes, please describe: ____

□ □ Do other people have difficulty understanding you?
If yes, please explain: ______________________________

□ □ Are there specific speech sounds that are more difficult for you to produce?
If yes, please explain: ______________________________

□ □ Do you have any weakness or difficulty moving your tongue, lips, or facial muscles?
If yes, please explain: ______________________________

□ □ Are you able to carry on a conversation with someone?
Please list any other speech/ language concerns: ______________________________
____

Swallowing

Describe any difficulties you have with swallowing, eating, or chewing: ______________________________
____

Please check any of the following that you experience:

□Throat clearing
□Loss of food from mouth onto chin or clothing
□ Difficulty clearing food from mouth
□ Difficulty drinking from cups or straws
□Difficulty swallowing pills
□Feeling that food is stuck in your throat
□Coughing during snacks or meals

YES	NO	
□	□	Are you on a special or restricted diet? If yes, please describe: ______________________________
□	□	Have you had pneumonia? If yes, please elaborate: ______________________________
□	□	Do you have asthma or chronic pulmonary disease?

Please list any other swallowing concerns: ______________________________
____

Please list any situations when your articulation is worse: ______________________________
____

Patient Name: ____________________
Date of Birth: ____________________

Communication Rating Scale

How would you complete the following sentences? Circle the number of your response that best describes how you perceive your speech at this time. *(0 = never; 1 = almost never; 2 = sometimes; 3 = almost always; 4 = always).*

Functional/Physical Level of Impairment	Never	Almost Never	Sometimes	Almost Always	Always
I am unable to communicate effectively with others.	0	1	2	3	4
It is difficult for other people to understand me.	0	1	2	3	4
During conversation, my family complains that they do not understand me.	0	1	2	3	4
During conversation, unfamiliar listeners do not understand me.	0	1	2	3	4
On the phone, people ask me to repeat what I say.	0	1	2	3	4
When speaking face-to-face, people ask me to repeat what I say.	0	1	2	3	4
My speech is not accurately perceived by voice recognition software.	0	1	2	3	4
Others have commented that I speak differently.	0	1	2	3	4
I work very hard to be understood by others.	0	1	2	3	4

Activity & Participation Level of Impairment	Never	Almost Never	Sometimes	Almost Always	Always
I communicate through text messaging or email to avoid speaking to others.	0	1	2	3	4
I speak with others less often because of my communication difficulty.	0	1	2	3	4
I tend to avoid speaking to groups of people because of my speech.	0	1	2	3	4
My communication skills prevent me from achieving my goals.	0	1	2	3	4
I am left out of conversations because of communication difficulty.	0	1	2	3	4
I am less out-going because of my communication difficulty.	0	1	2	3	4
My communication difficulty restricts my personal and social life.	0	1	2	3	4
My communication difficulty causes me to lose income.	0	1	2	3	4
My communication difficulty limits my career advancement.	0	1	2	3	4

Activity & Participation Level of Impairment	Never	Almost Never	Sometimes	Almost Always	Always
I feel like no one understands my communication difficulty.	0	1	2	3	4
My communication problem frustrates me.	0	1	2	3	4
I feel irritated when others ask me to repeat myself.	0	1	2	3	4
I feel embarrassed when I am asked to repeat myself.	0	1	2	3	4
I feel ashamed of my communication difficulty.	0	1	2	3	4
I feel less confident about my skills as a communicator because of my difficulty.	0	1	2	3	4
I feel other people become frustrated when they do not understand me.	0	1	2	3	4
My communication difficulty makes me feel incompetent.	0	1	2	3	4
I feel my relationship with others is affected by my communication difficulty.	0	1	2	3	4

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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: ________________________