



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: \_\_\_\_\_

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

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

- 1. What is the principle concern regarding the patient's communication skills?
2. What are the new concerns since the patient's discharge from therapy?
3. Please explain any changes in the patient's medical status since the previous evaluation.
4. Please explain any changes in the patient's occupational/ academic status since the previous evaluation.
5. Has the patient 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?



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 talking
Hoarseness
Frequent throat clearing
Feeling of something 'stuck' in throat
No concern

Mouth

- Oral habits (i.e. thumb sucking, use of pacifier, sucking on shirt strings)
Difficulty transitioning to solids
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
Complaints of 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
Struggle potty-training
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: \_\_\_\_\_