Evergreen Speech & Hearing Clinic, Inc.

Managing your hearing, speech, and balance needs since 1979

Bellevue Office
1800 116th Ave NE #103
Bellevue, WA 98004
F: 425.454.2036
P: 425.454.1883

Kirkland Office
12333 NE 130th Ln #430
Kirkland, WA 98034
F: 425.899.5054
P: 425.899.5050

Redmond Office
8301 161st Ave NE #208
Redmond, WA 98052
F: 425.883.0043
P: 425.882.4347

Patient Information and Insurance Form

Patient Information

Patient Name: ______________________ Date of Birth: ________ Age: ____ M F
Last *First* *MI*

Address:____________________ City:____________ State:_____Zip:________

Home Phone:______________ Work Phone:______________ Cell#: ______________

Referred By:______________ Primary Care Physician: ______________

Reason for Visit: ______________Email Address:______________

Person Responsible For Account

Name:______________________________

Address:____________________ City:____________ State:_____Zip:________

Home Phone:______________ Work Phone:______________ Employer:______________

Insurance

Insurance Company:______________ Subscriber:______________

Group #:______________ ID #:______________

Address:______________________________

Assignment and Release

Please Note: We will happily bill your Primary Insurance Carrier. Please forward appropriate information to your Secondary Insurance.

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 and I am financially responsible for any unpaid balance.

Signature of Patient or Guardian:______________________ Date:______________

09/13

ID Checked: □ ***yes*** □ ***no***

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Adult Speech History Form

Patient Name: ____

Date of Birth: ______________________ Date Form Completed: ______________

Primary Care Physician: ______________ Other Specialists Involved in Care: ______________

Patient Phone Number: ________________ Patient e-mail: ______________________

Principle concern in seeking this evaluation: ______________________________

____

Health History

Please answer yes or no to the following and give details if yes:

Any illnesses, injuries, or complications in childhood? □ yes □ no

If yes, please describe (including date and treatment): ____________________________

Please list any past or current conditions: ____________________________________

Are you taking any medications? □ yes □ no

Details: ____

Has your hearing been tested? If so, please indicate results. □ yes □ no

Results: ____

Is there a family history of speech, language, or learning problems? □ yes □ no

If yes, please explain (including syndromes, dysfluencies/stuttering, speech/language impairments): __________

____

Has your vision been tested? □ yes □ no

If so, please indicate results: ____

Do you have allergies? □ yes □ no

Details: ____

Speech and Language

Do you have any difficulties understanding others? □ yes □ no

If yes, please explain:____

Do other people have difficulty understanding you? □ yes □ no

If yes, please explain:____

Are there specific speech sounds that are more difficult to produce? □ yes □ no

If yes, please explain:____

Do you have any weakness or difficulty moving your tongue, lips or facial muscles? □ yes □ no

If yes, please explain:____

Are you able to carry on a conversation with someone? □ yes □ no

Please list any other speech/language concerns:______________________________

Swallowing

Describe any difficulties you have with swallowing, eating or chewing?

Please check any of the following which you may experience:

□ Throat Clearing

□ Feeling that food is stuck in your throat

□ Difficulty swallowing pills

□ Coughing during snacks or meals

□ Difficulty drinking from cups or straws

□ Difficulty clearing food from mouth

□ Loss of food from mouth on to chin or clothing

Are you on a special or restricted diet? □ yes □ no

If yes, please explain:____

Have you had pneumonia? □ yes □ no

If yes, please explain:____

Do you have asthma or chronic obstructive pulmonary disease? □ yes □ no

If yes, please explain:____

Please list any other swallowing concerns:________________________________

____

Please list any situations when your articulation is worse:________________________

____

Systems History

Ears/Nose/Throat/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 swallow
- ☐ Pain/discomfort after long periods of talking
- ☐ Hoarseness
- ☐ Tightness in throat
- ☐ Frequent throat clearing
- ☐ Feeling of something being ‘stuck’ in throat
- ☐ No concern

Mouth:
- ☐ Oral habits (i.e. thumb sucking, use of pacifier, sucking on shirt strings)
- ☐ Trouble breastfeeding
- ☐ Difficulty transitioning to solids
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Coughing frequently while eating
- ☐ Constant dry mouth
- ☐ Does not like/will not try new foods
- ☐ No concern

Other:____

____

Cardiovascular:
General:
- ☐ Chest pain/discomfort
- ☐ Shortness of breath with exertion
- ☐ 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:
General:
- ☐ Asthma
- ☐ Apnea/Dyspnea
- ☐ Frequent cough
- ☐ Shortness of breath
- ☐ Trouble achieving adequate breath support
- ☐ Frequent episodes of pneumonia, bronchitis or other infections
- ☐ No concern

Other:____

____

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

Other:____

____

Gastrointestinal/Genitourinary:
General:

- ☐ Heartburn/reflux
- ☐ Frequent nausea/vomiting/diarrhea
- ☐ Constipation
- ☐ Nighttime urination
- ☐ Kidney problems
- ☐ Struggle potty-training
- ☐ No concern

Other:____
____

Musculoskeletar:
General:

- ☐ Muscle/join pain
- ☐ Back pain
- ☐ Scoliosis
- ☐ No concern

Other:____
____

Skin:
General:

- ☐ Rashes
- ☐ Acne
- ☐ Eczema
- ☐ No concern

Other:____
____

Allergies:
General:

- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Details: ______________________________
- ☐ Medication allergies
- ☐ Details: ______________________________
- ☐ No concern

Other:____
____

Psychiatric:
General:

- ☐ Anxiety/stress
- ☐ Depression
- ☐ Sleep problems
- ☐ No concern

Other:____
____

Motor Development:
Fine Motor:

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

Gross Motor:

- ☐ Trouble balancing
- ☐ Falls often
- ☐ Easily trips over objects
- ☐ No concern

Other:____
____

Previous Diagnosis:
Please check all diagnosis your child has previously received:

- ☐ ADD
- ☐ ADHD
- ☐ Autism
- ☐ Asperger's Syndrome
- ☐ Cerebral Palsy
- ☐ Downs Syndrome
- ☐ Mental Retardation
- ☐ OCD
- ☐ No concern

Other:____
____