



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: _____



Adult Auditory Processing Form

Patient Name: _____

Last

First

MI

Date of Birth: ___/___/___ Today's Date: ___/___/___ Patient's preferred hand: Right Left
mo day year mo day year

Primary Care Physician: _____ Referred by: _____

Primary Concern: _____

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

Are you currently employed? YES NO

Describe: _____

Are you currently a student? YES NO

Highest level of education: _____

What are your hobbies and/or social activities? _____

Do your daily activities include:

- Giving presentations
- Listening to lectures
- Small group meetings
- Phone/video calls
- Phone/video conferences
- One-on-one meetings
- Working in a cubicle

Physical Health

YES NO

Are you taking any medications?
If yes, please list: _____

Have you had any surgeries? If yes, please list: _____

Have you had any injuries? If yes, please list: _____

Do you have any concerns about your overall physical health?
Explain: _____

Do you have any other diagnoses? (If yes, please provide a copy of reports if possible)



Family History

YES NO

- Do you have a family history of hearing loss before age 40?
Do you have a family history of speech / language / communication / learning disorders?
Please elaborate if "YES" to any of the above:

Hearing and Middle Ear History

YES NO

- Have you been seen by an Ear, Nose, and Throat physician?
Have you been seen by an audiologist for a hearing assessment?
Do you have any allergies?
Do you have frequent colds or sinus infections?
Do you have a history of ear infections?
Did you ever have P.E. tubes placed?
Have you had ear pain?
Do you experience any dizziness?
Do you have any ringing in your ears?
Do you have any sensitivities to sound?

Behaviors and Characteristics of Auditory Processing Challenges

The following list has some common characteristics of auditory processing disorder.

Please check those items that are difficult for you:

- Listening in noisy environments?
Listening for long periods of time?
Multi-tasking?
Spelling?
Taking notes?
Sarcasm and understanding jokes?
Recognizing where a sound came from?
Comprehending someone's intent (nonverbal cues)?
Interpreting the main idea of a spoken narrative?
Navigating social interactions?
Processing information quickly and efficiently?



Speech and Language History- General

Have you received previous speech and language therapy? YES NO

If yes, please explain (when, where, for how long): _____

Do you speak more than one language? YES NO

What languages do you speak? : _____

Are there concerns regarding understanding others and expressing yourself clearly? YES NO

If yes, please explain: _____

Do you have concerns about your ability to:

YES NO

- Think of the right words?
- Participate in conversation?
- Explain a process?
- Talk about past and present events?
- Express ideas concisely and clearly?
- Use appropriate inflection in your voice?



Scale of Auditory Behaviors*

Please rate each item by checking the number that best fits the behavior of the person you are rating. The numbers correspond to the frequency with which the behavior is observed. Please consider these items carefully when rating each possible behavior. A person may or may not display one or more of these behaviors. A high rating in one or more of the areas does not indicate any particular pattern. If you are undecided about a particular item, use your best judgment.

Date: _____ Completed By: _____

Table with 6 columns: Frequent, Often, Sometimes, Seldom, Never, Items. It contains 12 rows of behavioral items with corresponding rating boxes (1-5).

Score (Clinician Use): []

(For Adult & Ped. APD)
*SAB (Conlin, 2003, Schow et al. 2006, Shiffman, 1999: Simpson, 1981, Summers, 2003)
Adapted from the MAPA Assessment Manual



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 (e.g. 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 of 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: _____
- No concern**
- Other: _____

Motor Development

FINE MOTOR

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

GROSS MOTOR

- Trouble balancing
- Falls often
- Easily trips over objects
- No concern**
- Other: _____

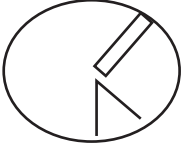
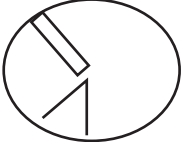
Previous Diagnoses

Please check all previous diagnoses.

- ADD
- ADHD
- Autism
- Asperger's Syndrome
- Cerebral Palsy
- Down Syndrome
- Mental Syndrome
- OCD
- No concern**
- Other: _____



FOR AUDIOLOGIST'S USE ONLY

<p>Otososcopic Inspection</p>  <p>RIGHT EAR</p>  <p>LEFT EAR</p>	<p>Active drainage observed <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Visible Congenital or traumatic deformity <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Visible evidence of significant cerumen <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Air-bone gap of 15dB (.5, 1, or 2KHz) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Other pertinent information:</p>
<p>Summary:</p>	
<p>Recommendations:</p>	
<p>Medical Clearance: _____</p> <p>Rescission Rights: _____</p> <p>Physician Letter: Dr. _____</p> <p>Hearing Instruments Initiated: _____</p> <p>Additional Notes:</p> <p>Audiologist Signature: _____ Reviewed: _____</p>	

For Speech Pathologist's use only. Areas assessed:

- | | | | |
|---|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Language | <input type="checkbox"/> Literacy | <input type="checkbox"/> Cognitive-Linguistics |
| <input type="checkbox"/> Oral mechanism | - Receptive | - Reading | <input type="checkbox"/> Fluency |
| | - Expressive | - Writing | <input type="checkbox"/> Voice |



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I acknowledge that I received a copy of Evergreen Speech & Hearing Clinic, Inc.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- ◆ This Notice informs me how Evergreen Speech & Hearing Clinic, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- ◆ This Notice explains in more detail how Evergreen Speech & Hearing Clinic, Inc may use and share my health information for other than treatment, payment, and health care operations.
- ◆ Evergreen Speech & Hearing Clinic, Inc. will also use and share my health information as required/permitted by law.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date