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: _____

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

Adult Voice History

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): _____
☐	☐	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.)? _____

_____

Voice

When did your voice concerns first start or become noticeable? _____

Have you consulted with your primary care physician or an ENT regarding this change? □ YES □ NO

If yes, please explain: _____

Was the onset sudden or gradual? _____

How much water do you drink in a typical day? _____

How much caffeine do you consume in a typical day? _____

Do you exercise on a regular basis? □ YES □ NO

Do you use alcohol? □ YES □ NO

If yes, how much and how often? _____

Do you use tobacco products or other recreational drugs? □ YES □ NO

If yes, how often? _____

If ceased, when? _____

Do you have any food or seasonal allergies? □ YES □ NO

If yes, to what? _____

Are there times you notice improved vocal quality? □ YES □ NO

If so when? _____

In what situations is vocal quality worse? _____

Have you previously received therapy? □ YES □ NO

Please rate on a scale of □-7 your vocal quality on a typical day (□: unable to use voice to communicate, 7: voice consistently sounds normal in all situations and contexts): _____

My goal for therapy is: _____

_____

Please provide any additional information that you feel may be relevant or that you'd like us to know. Your comments and opinions are very important. _____

_____

_____

_____

_____

_____

Voice Handicap Index

Check the response that indicates how frequently you have the same experience.

Part I-F	Never	Almost Never	Some-times	Almost Always	Always
1. My voice makes it difficult for people to hear me	0	1	2	3	4
2. People have difficulty understanding me in a noisy room	0	1	2	3	4
3. My family has difficulty hearing me when I call them throughout the house	0	1	2	3	4
4. I use the phone less often than I would like to	0	1	2	3	4
5. I tend to avoid groups of people because of my voice	0	1	2	3	4
6. I speak with friends, neighbors, or relatives less often because of my voice	0	1	2	3	4
7. People ask me to repeat myself when speaking face-to-face	0	1	2	3	4
8. My voice difficulties restrict personal and social life	0	1	2	3	4
9. I feel left out of conversations because of my voice	0	1	2	3	4
10. My voice problem causes me to lose income	0	1	2	3	4
Part II-P	Never	Almost Never	Some-times	Almost Always	Always
1. I run out of air when I talk	0	1	2	3	4
2. The sound of my voice varies throughout the day	0	1	2	3	4
3. People ask, “What’s wrong with your voice?”	0	1	2	3	4
4. My voice sounds creaky and dry	0	1	2	3	4
5. I feel as though I have to strain to produce voice	0	1	2	3	4
6. The clarity of my voice is unpredictable	0	1	2	3	4
7. I try to change my voice to sound different	0	1	2	3	4
8. I use a great deal of effort to speak	0	1	2	3	4
9. My voice is worse in the evening	0	1	2	3	4
10. My voice “gives out” on me in the middle of speaking	0	1	2	3	4
Part III-E	Never	Almost Never	Some-times	Almost Always	Always
1. I am tense when talking to others because of my voice	0	1	2	3	4
2. People seem irritated with my voice	0	1	2	3	4
3. I find other people don’t understand my voice problem	0	1	2	3	4
4. My voice problem upsets me	0	1	2	3	4
5. I am less outgoing because of my voice problem	0	1	2	3	4
6. My voice makes me feel handicapped	0	1	2	3	4
7. I feel annoyed when people ask me to repeat	0	1	2	3	4
8. I feel embarrassed when people ask me to repeat	0	1	2	3	4
9. My voice makes me feel incompetent	0	1	2	3	4
10. I am ashamed of my voice problem	0	1	2	3	4

For clinic use:

Voice Handicap Index: Part I-F _____ Part II-P _____ Part III-E _____ **Total** _____

Eating Assessment Tool (EAT-10)

Within the **past month,** to what extent have the following scenarios problematic for you? Circle the appropriate response.

	No problem				Severe Problem
My swallowing problem has caused me to lose weight.	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals.	0	1	2	3	4
Swallowing liquids takes extra effort.	0	1	2	3	4
Swallowing solids takes extra effort.	0	1	2	3	4
Swallowing pills takes extra effort.	0	1	2	3	4
Swallowing is painful.	0	1	2	3	4
The pleasure of eating is affected by my swallowing.	0	1	2	3	4
When I swallow food sticks in my throat.	0	1	2	3	4
I cough when I eat.	0	1	2	3	4
Swallowing is stressful.	0	1	2	3	4
For staff input only EAT-10 Scores:					

Reflux Symptom Index (RSI)

Within the B, how did the following symptoms affect you? Please rate each item below on how "bad" it is (that is, the amount of each problem that you have). Use the following scale for rating the amount of the problem:

	No problem					Always
1. Hoarseness or a problem with your voice?	0	1	2	3	4	5
2. Clearing your throat?	0	1	2	3	4	5
3. Excess throat mucus or postnasal drip?	0	1	2	3	4	5
4. Difficulty swallowing food, liquids or pills?	0	1	2	3	4	5
5. Coughing after you ate or lie down?	0	1	2	3	4	5
6. Breathing difficulties or choking episodes?	0	1	2	3	4	5
7. Troublesome or annoying cough?	0	1	2	3	4	5
8. Sensations of something sticking in your throat or a lump in your throat?	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up?	0	1	2	3	4	5
For staff input only RSI Score:						

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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 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
- ❑ Cognitive Impairment
- ❑ OCD
- ❑ **No concern**
- ❑ Other:_____

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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 informa tion as required/permitted by law.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date

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