Salubris Speech Therapy LLC

Adult
Voice Intake Form

DATE: _____

Identifying Information

FULL NAME: _____ DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER OCCUPATION: _____

HOME: _____ (STREET ADDRESS) _____ (APT) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

PHONE: _____ EMAIL: _____

EMERGENCY CONTACT: _____ (NAME) _____ (RELATIONSHIP) _____ (PHONE)

Primary Care Physician

FULL NAME: _____ OFFICE PHONE: _____

OFFICE: _____ (STREET ADDRESS) _____ (APT) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

Insurance Information

Primary

INSURANCE COMPANY: _____ PLAN NAME: _____

POLICY #: _____ GROUP: _____ CONTACT: _____

Secondary

INSURANCE COMPANY: _____ PLAN NAME: _____

POLICY #: _____ GROUP: _____ CONTACT: _____

Medical History

Under a physician's care? ☐ YES ☐ NO If yes, please explain: _____

Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check all that apply:

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Asthma
- ☐ Breathing difficulty
- ☐ Cancer: _____
- ☐ Colds often
- ☐ Cochlear implant(s)
- ☐ Concussion
- ☐ Confusion
- ☐ Dentures: ☐ Upper ☐ Lower
- ☐ Diabetes
- ☐ Digestive difficulty
- ☐ Dyslexia
- ☐ Ear infections: How often? _____
- ☐ Ear tubes
- ☐ Encephalitis/Meningitis
- ☐ Falls
- ☐ Flu: How often? _____
- ☐ Intellectual disability
- ☐ Measles
- ☐ Memory problems: ☐ Short-term ☐ Long-term
- ☐ Meniere's disease
- ☐ Mumps
- ☐ Noise exposure
- ☐ Neuromuscular disease
  - ☐ Amyotrophic Lateral Sclerosis
  - ☐ Epilepsy
  - ☐ Multiple Sclerosis
  - ☐ Muscular Dystrophy
  - ☐ Parkinson's Disease
  - ☐ Other: _____
- ☐ PEG tube
- ☐ Pneumonia
- ☐ Poor appetite

Please check all that apply:

- ☐ Schizophrenia
- ☐ Seizures/convulsions
- ☐ Sensory integration disorder
- ☐ Sinusitis
- ☐ Sleeping difficulty
- ☐ Stroke
- ☐ Stuttering / cluttering
- ☐ Swallow difficulty
- ☐ Tinnitus
- ☐ Tonsillectomy
- ☐ Tracheostomy
- ☐ Traumatic brain injury:
  - ☐ Auto accident
  - ☐ Post-concussion
  - ☐ Other: _____
- ☐ Vocal fold pathology:
  - ☐ Hoarseness
  - ☐ Laryngectomy
  - ☐ Polyps / Nodules
  - ☐ Speech valve
  - ☐ Other: _____

Any other serious illness, injury, or surgery? _____

Communication

Do you have a voice problem? ☐ YES ☐ NO If yes, describe: _____

Previously evaluated? ☐ YES ☐ NO If yes, when? Results? _____

What therapy did you receive? _____

Do you have a hearing problem? ☐ YES ☐ NO If yes, describe: _____

Previously evaluated? ☐ YES ☐ NO If yes, when? Results? _____

Hearing aids? ☐ RIGHT ☐ LEFT

Do you have a vision problem? ☐ YES ☐ NO If yes, describe: _____

Glasses? ☐ YES ☐ NO

Do you have a history of learning disability? ☐ YES ☐ NO If yes, describe: _____

Swallowing

Are you on a modified diet? ☐ NO ☐ YES: ☐ Soft/chopped ☐ Pureed foods ☐ Thickened liquids (Nectar/Honey)

Do you cough/clear your throat during meals? ☐ YES ☐ NO If yes, describe: _____

_____

Does food get "stuck" in your throat? ☐ YES ☐ NO If yes, types: _____

Do you have trouble swallowing pills? ☐ YES ☐ NO

Have you ever had the following swallow tests?

- ☐ Modified Barium Swallow Study (MBSS). Results: _____
- ☐ Fiberoptic Endoscopic Evaluation of Swallow (FEES). Results: _____

Any other therapy at this time? ☐ Physical therapy ☐ Occupational therapy ☐ Counseling/Psych.

Any additional comments?

_____

_____

_____

_____

_____ SIGNATURE

_____ RELATIONSHIP

_____ DATE

Please return by email to info@kissimmeespeech.com, or fax to (321) 333-5682

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