Name ____ DOB ________________ Today's Date: ____________

Preferred Phone (cell/work/home) _______________ Email Address: ___________________________________

Emergency Contact Name: __________________________ Emergency Contact Phone: ____________________

Referring Physician_____________________________ Primary Care Physician _________________________

Medications Currently Taking: ____

How did you choose HonorHealth? ☐ Physician Recommended ☐Previous patient ☐ Friend

☐ Recommended through media ☐Other___________________________________

Section 1: Language, memory, thinking problems: <u>SKIP if you do not have trouble with these areas</u>. Please indicate if any of the following problems apply to you following your injury/accident/illness:

	Yes	No
Difficulty finding words	☐	☐
Difficulty understanding what you read	☐	☐
Difficulty understanding language	☐	☐
Difficulty saying as much as I would like (verbal expression)	☐	☐
Difficulty writing	☐	☐
Difficulty with work or academics (eg studying, homework, tests, projects)	☐	☐
Problems making decisions	☐	☐
Difficulty with relationships/friendships	☐	☐
Mood changes (anger, depression, anxiety, difficulty controlling)	☐	☐
Memory problems	☐	☐
Dizziness	☐	☐
Headaches	☐	☐
Attention problems	☐	☐
Fatigue	☐	☐
Organizational Problems	☐	☐
Other (please specify) ____		

Based on your responses above, are their activities/tasks that you previously participated in that you have now difficulty with? (eg: paying bills, managing time, having enough energy to make it through all cognitive demands of your day?) ______Yes _______ No If yes, please describe____

____

Please indicate your primary goal(s) for speech therapy:

☐ Improve my ability to talk	☐ Improve my organizational skills
☐ Improve my ability to understand language	☐ Improve my memory
☐ Improve my ability to find words	☐ Improve my attention
☐ Help me get back to work	☐ Improve my ability to multitask
☐ Improve my ability to do my school work.	☐ Other, please specify: ___________

Continue on the back side ------------>

Section 2: Upper Airway/Throat Problems: **SKIP sections 2, 3, and 4 if you do not have upper airway problems (throat, voice, swallowing, etc)**

Please check any of the following which apply to you:

☐ Talk loudly and often ☐ Voice sounds hoarse, raspy, weak, strained ☐ Trouble producing loud or soft voice ☐ Voice gets tired quickly ☐ Difficulty using voice at work or on the phone	☐ Difficulty swallowing food, liquids, or pills ☐ Difficulty swallowing saliva ☐ Feeling a lump in your throat before, during, or after eating or drinking ☐ Gagging while trying to eat
☐ Difficulty singing ☐ Loss of pitch range during singing ☐ Difficulty changing tone of voice during performances ☐ Need a baseline voice exam for performers	☐ Cough or clear throat often ☐ Difficulty breathing (in episodes or constant) ☐ Tightness in neck with worsening breathing ☐ Shortness of breath during exercise ☐ Unusual airway sounds during awake breathing

My voice is (circle): normal hoarse raspy breathy whispered absent strained weak

My swallowing is (circle):

normal abnormal difficult I aspirate when I swallow I cough when I swallow

Section 3: Swallowing Problem: **SKIP if you do not have trouble swallowing**

Have you had a swallowing study before? (endoscopic or in x-ray?) ___No ___Yes. If yes, when? ______

Have you experienced unintentional weight loss? ___No ___Yes; if yes how much (apprx lbs) ______

Have you seen a dietitian in the last six months? ___No ___Yes; if yes, did your problem improve? __________

What foods are you intentionally avoiding when you eat/drink? ______________________________________

Section 4 Voice Problem: **SKIP if you do not have trouble with your voice**

How much water do you drink each day? _________________ Ounces of caffeinated beverages? __________

How many alcoholic beverages do you consume each day? _______________________________

Do you smoke, vape, or use tobacco products? ___No ___Yes; if yes, how much per day? ____________

Are you exposed to second hand smoke? ___No ___Yes; describe: _________________

Occupation: ____________________________ How long have you worked there? _______________

Is voice necessary for your position? ___No ___Yes What percentage of the day do you use your voice? ____%

Do you experience difficulties with your voice at work? ___No ___Yes; if yes, explain:_____________________

Do you take medication for acid reflux? ___No ___Yes; If yes, describe: ______________________________

Patient Signature:____ Date:___________________