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Full Name:_____

Name by which you are called: _____

Address: _____ Date of Eval: _____

_____ Client's Home Phone #: _____

Cell Phone # _____

Work: _____ Work Phone: _____

Contacts/Caretakers: _____ Phone #: _____

DOB: _____ Age: _____

Siblings: _____ Gender: ____ Age: _____

Siblings: _____ Gender: ____ Age: _____

Siblings: _____ Gender: ____ Age: _____

What language(s) is/are spoken at home? _____

By whom? _____

Who referred you to **Help Me Speak**? _____

What are your main concerns that bring you to **Help Me Speak?**: _____

_____

Have you discussed these concerns with a professional?___ If so, with whom? _____

Results of this conversation? _____

Referring Physician: _____

List any medical diagnoses & the 1st date given: _____

_____

What do you hope to accomplish by coming to **Help Me Speak**? _____

_____

Person completing form_____ Relationship to Client _____

MEDICAL INFORMATION:

List any medical diagnoses: DATE of onset:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Circle all that apply:

Headaches	Dizziness	Encephalitis	Hearing Loss	Pneumonia
Seizures	PEG Tube	Diabetes	Hypertension	Respiratory Issues
Cardiac Issues	CVA (Stroke) (Date: _____)			Head Injury (Date:_____)
OSA	UARS	SDB	Sleep Study date: _____	

Other: _____

Have you been referred to any of the following specialists? (**circle** those that apply)

Audiologist	Otolaryngologist (ENT)	Gastroenterologist	Neurologist	Psychologist
Psychiatrist	Occupational Therapist	Physical Therapist		

Please explain the reasons for these referrals:

_____

_____

_____

When did you first notice the presenting difficulty? (the reason for the eval)

_____

_____

Describe any related medical history of the difficulty in **detail**. Please list any hospitalizations, etc. with **dates** of each.

_____

_____

_____

_____

_____

_____

_____

_____ (attach other info &/or medical reports)

What type of previous therapy has been used for this difficulty? Please describe in detail:

_____

_____

_____

_____

_____

_____

_____

(attach other info &/or reports)

What other medical professionals have been consulted about this issue? Results?

_____

_____

List any medications taken & reasons for each: _____

_____

Are you taking any supplements? If yes, which ones, what type, and when did you start taking them?

_____

_____

_____

Do you have problems with hearing or vision? Please explain: _____

Do you wear glasses? Yes No Hearing Aid(s)? Yes No

History of Upper Respiratory Infections/cold/sinus infections? Y or N

How many? _____ How often do they occur? _____

What time of year do they occur? _____

Do you have a history of ear infections, otitis media, or uninfected fluid in the middle ear? _____

In which ear? R L Both How many? _____

How often do they occur? _____

Have you ever been treated by an ear, nose, and throat specialist? Y or N

Who? _____ When? _____

Allergies?_____ Sinus problems? _____

Treatment for above? _____

Food allergies?_____

Or sensitivities? _____

SLEEP HABITS:

Have you been told you snore? Yes No

What time do you go to bed at night?_____

How long does it take you to fall asleep? _____

Do you sleep through the night? Yes No

How many times do you awaken at night? _____

At what times? _____

In what position do you sleep? _____

What time do you awaken each morning? _____

What other sleep challenges do you have? _____

_____

Obstructive Sleep Apnea? Yes No

Upper Airway Resistance Syndrome (UARS)? Yes No

Sleep Disordered Breathing? Yes No

Sleep Study date: _____

EATING HABITS: ****Please write down what you eat for 3 days & bring this list to the evaluation.**

glasses liquid with meals? _____ Wash down food? Y N

Fast or slow eater? Chew food adequately? Y N Burp excessively after meals? Y N

Digestive problems? Y N _____ Resist difficult to chew foods? _____

Are you a picky eater? ___yes ___no

Food preferences? Please list **10 or more** Proteins: (e.g. meats, poultry, fish, & dairy)

_____

_____

Please list **10 or more** Fruits/Vegetables:

_____

_____

Please list **10 or more** Carbs:

_____

_____

Food dislikes? _____

Favorite tastes/flavors? _____

Preferred textures? _____

Preferred temperature? _____

Special diet/food restrictions? _____

Other? _____

COMPREHENSION AND UNDERSTANDING:

Are you easily confused when there are many things taking place around you? If "yes", please explain.

How do you respond when given directions?

How do you respond to simple questions?

How would you describe your intelligence or thinking skills?

COMMUNICATION STATUS:

How would you describe your current communication ability? (check all that apply)

____Almost never communicates
____Sometimes communicates
____Communicates frequently

____It is *very* easy for me to be understood when the topic of conversation is known.
____It is *fairly* easy for me to be understood when the topic of conversation is known.
____It is *difficult* for me to be understood when the topic of conversation is known.

____It is *very* easy for me to be understood when the topic of conversation is not known.
____It is *fairly* easy for me to be understood when the topic of conversation is not known.
____It is *difficult* for me to be understood when the topic of conversation is not known.

____I am usually understood by other people who don't know me well.
____I am usually NOT understood by other people who don't know me well.

Please describe how you communicate: _____

_____

_____

_____

Which of the following best describes your speech?

___easy to understand
___difficult for others to understand
___difficult for others to understand
___almost never understood by others

Which of the following statements best describes your reaction to your speech?
___ Am easily frustrated when not understood
___Am not aware of any speech/ communication problem
___Has been teased about my speech
___Tries to say sounds or words more clearly when asked
___Am successful in saying sounds or words more clearly when I try

I am aware of my communication difficulties? ___yes ___no

If Yes, how does this awareness impact on my social/emotional status? _____
_____
_____

Do you have difficulty producing certain sounds? ___yes ___no
If so, which ones are difficult? _____

Do you hesitate and/or repeatedly say sounds or words? ___yes ___no
If so, which ones? _____

Do you "get stuck" when attempting to say a word? ___yes ___no
Explain: _____

Indicate your agreement with the following statements (circle one choice):

1. I am able to communicate effectively to express pleasure or displeasure.
Strongly disagree Disagree Not Sure Agree Strongly Agree

2. I am able to communicate to get help when needed.
Strongly disagree Disagree Not Sure Agree Strongly Agree

3. My biggest communication priority is to request things I need.
Strongly disagree Disagree Not Sure Agree Strongly Agree

4. My biggest communication priority is to get or give information (e.g. ask/answer questions)
Strongly disagree Disagree Not Sure Agree Strongly Agree

5. My biggest communication priority is to initiate & maintain conversations.
Strongly disagree Disagree Not Sure Agree Strongly Agree

A typical day for me is: _____
_____
_____
_____
_____
_____

EDUCATIONAL HISTORY:

Highest grade completed: _____

Degree(s): _____

Name of Institution: _____

Have you ever had difficulty with the following areas prior to your illness or accident? (circle all that apply)

Understanding Attention Reading Speaking Writing Math Memory

Problem Solving Visual/Spatial Directions

WORK HISTORY: Currently Employed? Yes No Date of Retirement?_____

Occupation: _____ Place of Employment: _____

Job Duties:

Are you currently driving? Yes No

What are your household responsibilities? (circle all that apply)

Computer tasks Cleaning Laundry Balancing Checkbook Grocery Shopping
Child Care Yard Work Household Repairs Driving
Other: _____

SOCIAL/ EMOTIONAL SKILLS:

Check behaviors that you feel best describes you:

__Overly active
__Overly quiet
__Defiant
__Easily controlled /Passive
__Nervous
__Destructive
__Dependent upon routines
__Very shy
__Perfectionist
__Friendly, outgoing
__Imaginative & creative
__Interacts well with others
__Mouth breather
__Interrupted/Unusual eating habits
__Interrupted/ Unusual sleeping habits

Please list any other information that has not been asked in the above questions: _____

_____

_____

_____

_____

_____

_____

_____

Thank You!