Name MRN DOB (Patient Identification)	VCU Health Community Memorial Hospital **SPEECH THERAPY ADULT HISTORY**

VCU Health Community Memorial Hospital
Hendrick Rehabilitation Center
750 Lombardy Street
South Hill, Virginia 23970
Phone. 434-447-0895 Fax 434-774-0873

Do you need help filling out this form? ☐ Yes ☐ No

Name: _____ Date: _____

Address: _____
Street City State Zip Code

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail: _____

Contact name: _____ Phone # _____
(Caregiver/ Spouse/ Significant Other/ Son/ Daughter)

Physician's name: _____ Physician's name: _____
Address: _____ Address: _____
Phone #: _____ Phone #: _____

Name of person completing this form (if not patient) _____
Relationship to patient _____

Educational History School _____ Highest Grade Attended _____

Employment History Occupation _____ Are you currently employed? ☐ Yes ☐ No

MEDICAL HISTORY Is your general health: ☐ Excellent ☐ Average ☐ Poor
If poor, explain: _____

Have you experienced any serious physical illnesses? ☐ No ☐ Yes If yes, explain: _____

_____

Have you ever undergone any significant operations or had an invasive procedure? ☐ No ☐ Yes
If yes, explain: _____

Have you ever been hospitalized? ☐ No ☐ Yes If yes, explain: _____

_____

List any significant medical conditions or problems you have experienced: _____

_____

_____

DT-SPEECHPATH

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Bring a list of all current medications, over-the-counter medications, or herbal supplements you are currently taking to the evaluation. You may also list your medications: _____

_____

_____

STATEMENT OF THE PROBLEM

Reason for referral: _____

_____

Describe the problem: _____

_____

_____

See table below and rate how often you have these common deficits:

Symptom	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

Are there any other difficulties besides what is listed above? ☐ No ☐ Yes

If yes, describe: _____

_____

Do you currently, or have you ever, experienced any pain associated with this problem: ☐ No ☐ Yes

If yes, describe: _____

_____

DT-SPEECHPATH

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Was this onset gradual or sudden? Describe: _____

_____

Were there any special circumstances surrounding this onset? ☐ No ☐ Yes
If yes, describe: _____

_____

In the past, have you ever been seen by a Speech-Language Pathologist for problems with speech, language, hearing, cognition, or swallowing? ☐ No ☐ Yes

If yes, When: _____

Where (eg. home health, inpatient rehab, etc.): _____

Results: _____

Are you currently receiving:

Occupational Therapy: ☐ No ☐ Yes

If yes, how often: _____ Where: _____

Physical Therapy: ☐ No ☐ Yes

If yes, how often: _____ Where: _____

What is your goal of speech therapy? _____

_____

_____

_____

Please feel free to mention any other information that you feel will be helpful: _____

_____

_____

_____

_____	_____	_____
Patient Signature	Date	Time
_____	_____	_____
Name/Signature of Reviewing Speech-Language Pathologist	Date	Time

DT-SPEECHPATH