Speech Therapy: Client Questionnaire & Screening Form

How did you hear about our services?

Please check if you have or have had any of the following:

- Diabetes
- Heart Attack/Problems
- Cancer
- Head or Neck Cancer
- Shortness of Breath
- Allergies
- Lung Disease
- Circulatory/Vascular Problems
- Neurological Problems
- High Blood Pressure
- Stroke/TIAs
- Reflux/GERD/heartburn
- Gastrointestinal Problems
- Dizziness
- Headaches
- Traumatic Brain Injury
- Mental or Emotional disorders/difficulties
- Substance Abuse (current or in recovery)
- Arthritis
- Swallowing Problems
- Hearing Loss
- Voice Problems or Changes
- Slurred Speech
- Other
- Dizziness
- Headaches
- Traumatic Brain Injury
- Mental or Emotional disorders/difficulties
- Substance Abuse (current or in recovery)
- Arthritis
- Swallowing Problems
- Hearing Loss
- Voice Problems or Changes
- Slurred Speech
- Other

Please list, with approximate date, all accidents, surgeries and hospitalizations:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Please list all your current medications, supplements, and homeopathic treatments:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

What are the main reasons you are seeking Speech Therapy?

____________________________________________________________________________________________

Have you had any treatment for the problem which brings you here today? Yes _____ No _____

If “yes,” please describe

____________________________________________________________________________________________

Have you had any physical or speech therapy this year? Yes _____ No _____ If yes, please explain:

____________________________________________________________________________________________

Please indicate on the figures the area(s) in which you are experiencing symptoms.

Please indicate on the scale below the intensity of your symptoms:

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<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>Intolerable</td>
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Was the onset sudden or gradual:

____________________________________________________________________________________________

Patient name: ____________________________    Date: ____________________