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

_____

_____

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.

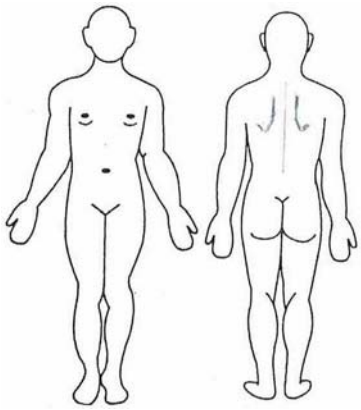
Please indicate on the scale below the intensity of your symptoms:

0 1 2 3 4 5 6 7 8 9 10

None Intolerable

Was the onset sudden or gradual:

_____



Patient name: _____ Date: _____