AMPLIFY
SPEECH THERAPY • FIND YOUR VOICE

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Personal History Form

Thank you for taking the time to complete this form. The information provided below will help in delivering accurate treatment for your communication, swallowing and/or cognitive needs. All information is confidential.

Return these forms by email, fax or regular mail to the addresses above in order to establish an account on the patient portal and prior to your initial visit.

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip: _____

Email Address: _____

Emergency contact name & phone number: _____

I am interested in receiving __ teletherapy __ home visits

Referred by: _____ Phone: _____

Address: _____

Primary care physician (if different): _____

Insurance Carrier: __ Medicare __ Private Pay __ Other: _____

Speech-Language History

Do you speak any other languages besides English? __ Yes __ No

If so, which languages and when did you learn them? _____

Please check all that apply

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			
Difficulty completing a task			
Speech is unclear			
Oral weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

Do you experience any other difficulties besides what is listed above?

_____

When was this problem first noticed? _____

Did the problem begin suddenly or develop over time? _____

Have you been seen by any other rehabilitation professionals?

- ☐ **Speech therapy**: where: _____ when: _____
- ☐ **Physical Therapy**: where: _____ when: _____
- ☐ **Occupational Therapy**: where: _____ when: _____
- ☐ **Other**: _____

If previously seen by speech therapy, what were the conclusions or recommendations?

_____

How or where does the speech-language difficulty impact you the most?

_____

What do you hope to get out of speech-language therapy? _____

_____

Medical History: please check all that apply. Please provide the dates where applicable

- ☐ Heart attack
- ☐ Heart troubles
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Chronic laryngitis
- ☐ Acid reflux
- ☐ Ear infections
- ☐ Meningitis
- ☐ Seizures
- ☐ Head injury
- ☐ Neurological conditions
- ☐ Allergies
- ☐ Cancer
- ☐ Head/neck cancer
- ☐ Shingles
- ☐ Bronchitis
- ☐ COPD
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Arthritis
- ☐ Hearing loss
- ☐ Cerebral palsy
- ☐ Intellectual deficits, MR
- ☐ Cleft palate
- ☐ Chronic colds
- ☐ Facial nerve palsy
- ☐ Emotional or psychological issues
- ☐ Multiple sclerosis
- ☐ Huntington's or Parkinson's Disease
- ☐ Voice issues or changes
- ☐ Vocal polyps or nodules

Have you been hospitalized within the last 5 years? If so, why? Where?

_____

_____

Please list all medications you are taking (or provide a copy with this form).

_____
_____

_____

Do you use any of the following assistive devices?
__ Wheelchair __ Walker __ Cane __ Hearing aid __ Other

Social History

Marital Status: __ Single __ Married __ Divorced __ Widowed

Spouse or partner's name: _____
Who lives in the home? _____

Occupation: _____

Do you currently work? __ Yes __ No

Highest level of education you earned? _____

Please provide any additional information you feel might be helpful in the evaluation or treatment process.

_____

_____

Person completing this form, if different from the client: _____

Relationship to the client: _____

Signature: _____ Date: _____