CAPITAL HEALTH

Rehabilitation Services Department
Speech-Language Pathology

Patient name:
Date of birth:
Account#

Summary List– Please fill out only the white sections of this form and sign below.

Past Medical history Check all that apply	Yes	No	Therapist Comments
Heart problems	☐	☐	
High blood pressure	☐	☐	
Asthma / Lung problems / COPD	☐	☐	
Cancer / Chemotherapy / Radiation	☐	☐	
Diabetes	☐	☐	
Kidney problems / Dialysis	☐	☐	
Stroke / TIA	☐	☐	
Thyroid disease	☐	☐	
Parkinson's disease	☐	☐	
Seizures	☐	☐	
Swallowing problems	☐	☐	
Hearing problems	☐	☐	
Vision problems	☐	☐	
Injury to head / Concussion	☐	☐	
Dementia	☐	☐	
History of surgeries	☐	☐	
Reflux / GERD	☐	☐	
History of pneumonia	☐	☐	
History of motor vehicle accident	☐	☐	
Fall with loss of conciousness	☐	☐	
Other	☐	☐	

Fall Risk Assessment	Yes	No	Therapist Comments
Are you taking more than 4 prescription medications?	*☐	☐	
Have you had a fall in the last 6 months?	*☐	☐	
Do you have problems with your balance?	*☐	☐	

Patient responses have not identified a risk for falls ☐

Patient response identified possible fall risk*; education provided ☐

ALLERGIES

CURRENT MEDICATIONS

Occupation:

Highest level of education:

Current problem: Are you having any of the following?	Yes	No	Therapist Comments
Difficulty finding the word you want to use	☐	☐	
Difficulty pronouncing words	☐	☐	
Stuttering or stammering	☐	☐	
Voice hoarseness or discomfort	☐	☐	
Memory loss	☐	☐	
Problems with attention	☐	☐	
Problems with general thinking	☐	☐	

Social History	Yes	No	Therapist Comments
Do you smoke?	☐	☐	
Do you drink alcohol?	☐	☐	
Do you use drugs?	☐	☐	
Do you have anxiety?	☐	☐	
Do you get depressed?	☐	☐	
Do you have a need to discuss any emotional or physical harm that you may be experiencing?	☐	☐	

Additional Questions

Please decribe your reason for coming to therapy:

How long have you had this problem?

What do you hope to achieve through Speech-language therapy?

Please list any previous evaluations / therapy you have received (Speech, ENT, Hearing, Neurological, Physchological)

Date and type of evaluation:_____ Date and type of evaluation:_____

Date and type of evaluation:_____ Date and type of evaluation:_____

Is there anything that would interfere with your participation in therapy? N☐ Y☐

Would you like to receive information regarding: Support group☐ Nutritio☐ Advance Directi☐ No, thank y☐

Patient signature:_____ Date:_____ Time: _____

Therapist signature,lic# / initial:_____ Date:_____ Time: _____