Speech/Language/Cognition/Voice:

Why are you seeking speech/language services? _____
_____
Describe your main concerns: _____
When was the problem first noted? _____
How do you react to your communication difficulties?

- ☐ I try again
- ☐ I become angry/frustrated
- ☐ I give up
- ☐ I don't notice the problem
- ☐ Other:_____
  _____

Has your family, physician, or others noticed your communication difficulties? If yes, please explain: _____
How would your family or friends describe your speech? _____
Has there been any changes to your voice (i.e. hoarse, breathy, loss of volume)? If yes, please explain: _____
Have you received any of the following services previously?:

- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Other:_____
- ☐ None of the above

Please indicate if you have noticed difficulty with any of the following:

- ☐ Expressing your wants and needs
- ☐ Others having difficulty understanding you
- ☐ Understanding others
- ☐ Short term memory
- ☐ Long term memory
- ☐ Word finding (e.g. remembering names of objects)
- ☐ Losing your train of thought
- ☐ Problem solving
- ☐ Organization
- ☐ Reading
- ☐ Writing
- ☐ Other: _____
  _____

Do you wear glasses or contacts? Yes No
Do you wear dentures? Yes No
Do you wear hearing aids? Yes No

Swallowing:

Please indicate if you have difficulty with any of the following:

- ☐ Chewing food
- ☐ Swallowing food or liquid
- ☐ Drooling
- ☐ Moving food to the back of your mouth
- ☐ Managing liquids
- ☐ Length of time to complete a meal
- ☐ Food feels stuck in your throat
- ☐ Watery eyes when eating/drinking
- ☐ Coughing
- ☐ Choking
- ☐ Holding cup/utensils
- ☐ Clearing food/liquid from your mouth
- ☐ Other: _____

Please describe any additional difficulties with eating, swallowing, chewing, textured foods, etc.:
_____
Do you avoid any foods or drinks that are difficult? _____

Have you had any of the following diagnostic tests related to this problem?

- ☐ Modified Barium Swallow Study
- ☐ Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
- ☐ X-ray
- ☐ MRI
- ☐ CT Scan
- ☐ ENT Scope
- ☐ Other: _____ _____

Please describe in detail any of the above tests (where, when, results, etc): _____
_____
Have you had any recent hospitalizations? If so, what hospital? How long were you in the hospital? What was the reason for the hospitalization? _____
_____