

# SPS

## Speech Pathology Services

### PATIENT INFORMATION & CONSENT FORM

#### Patient Information

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Work # \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Social Security # \_\_\_\_\_

#### Insured Information

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Work # \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Social Security # \_\_\_\_\_

#### Insured Employment Information

Employer \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

#### Insurance Information

Primary \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Referring Physician/Referral Source \_\_\_\_\_  
Referral # \_\_\_\_\_ Date of Recheck \_\_\_\_\_  
Reason for visit \_\_\_\_\_  
Is this injury or condition related to work \_\_\_\_\_ auto accident \_\_\_\_\_ ? Date of Illness \_\_\_\_\_

#### Personal Information

Type of Work \_\_\_\_\_ Education/Schooling \_\_\_\_\_  
Married Y \_\_\_ N \_\_\_ Spouse's name \_\_\_\_\_ # of years \_\_\_\_\_  
Children Y \_\_\_ N \_\_\_ Names & Ages \_\_\_\_\_

Speech Pathology Services does not accept credit cards.

I hereby authorize my insurance company to pay directly to \_\_\_\_\_ medical benefits otherwise payable to me and I will be responsible to said \_\_\_\_\_ for all expenses incidental to treatment rendered not paid under this plan.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
Guardian (if required) \_\_\_\_\_ Date \_\_\_\_\_

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### Case History and Information for Paradoxical Vocal Fold

#### Breathing

1. Describe your breathing problems including date of onset. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What help have you sought and how effective has it been? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Have you been diagnosed with asthma? \_\_\_\_\_ Date: \_\_\_\_\_

Do asthma medications relieve your symptoms? \_\_\_\_\_  
\_\_\_\_\_

4. Are you generally short of breath or do your breathing difficulties occur in episodes?  
\_\_\_\_\_ If episodic, how often? Daily \_\_\_ Weekly \_\_\_ Monthly \_\_\_

Do medications relieve your symptoms? \_\_\_\_\_  
\_\_\_\_\_

5. If there is stridor, wheezing, or some other sound associated with your breathing difficulty,  
can you imitate it? \_\_\_\_\_

6. When you are having difficulties, what do you do to make breathing easier? \_\_\_\_\_  
\_\_\_\_\_

Is there a certain time of day or a certain environment that causes you to have problems? \_\_\_\_\_  
\_\_\_\_\_

7. What makes your breathing worse? \_\_\_\_\_  
\_\_\_\_\_

8. Overall, is the breathing difficulty getting better or worse? \_\_\_\_\_  
\_\_\_\_\_

9. What type of athletic or structured physical activities do you participate in? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does it affect your breathing? \_\_\_\_\_

10. Does stress or activity affect your breathing? \_\_\_\_\_

11. Have you had recent dental work? If so, please describe. \_\_\_\_\_

12. Please check if you have experienced any of the following:

\_\_\_ gastroesophageal reflux                      \_\_\_ hoarseness

\_\_\_ hiatal hernia                                      \_\_\_ sore throats

\_\_\_ chronic cough                                    \_\_\_ throat clearing

\_\_\_ wake at night with a severe cough or inability to breath

\_\_\_ bitter or acid taste in mouth, particularly in the morning

13. Describe your use of the following:

\_\_\_ tobacco products                      How many per day? \_\_\_\_\_

\_\_\_ alcohol                                      How frequent? \_\_\_\_\_ How much? \_\_\_\_\_

\_\_\_ caffeine                                      How frequent? \_\_\_\_\_ How much? \_\_\_\_\_

\_\_\_ daily water consumption                      How much? \_\_\_\_\_

14. Medical History

Surgeries: \_\_\_\_\_

Major illnesses: \_\_\_\_\_

Current Medications: \_\_\_\_\_

**Reflux**

1. Is your voice ever hoarse? \_\_\_ no \_\_\_ yes If yes, when is it most likely to occur? \_\_\_\_\_

\_\_\_\_\_

Does it occur just before or after you have breathing difficulties? \_\_\_\_\_

2. Do you have frequent feelings of (circle all that apply):

heartburn    indigestion    burning in the throat    problems swallowing.

If you circled any of these, when is this most likely to occur? \_\_\_\_\_

Does it occur just before or just after you have breathing difficulties? \_\_\_\_\_

3. How many meals a day do you typically eat and what do you typically eat at each meal? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. If you eat snacks, how often do you eat them? \_\_\_\_\_

What do you typically eat for a snack? \_\_\_\_\_

How late in the evening do you snack? \_\_\_\_\_

5. What is your typical daily consumption of products with caffeine (coffee, tea, cola, etc.)?

\_\_\_\_\_

6. What is your typical daily consumption of fluids without caffeine (water, juice, milk, soda, etc.)? \_\_\_\_\_

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### EMOTIONAL

1. Does your level of stress or anxiety have an effect on your breathing? \_\_\_\_\_
  2. When your breathing difficulties began were there any particularly stressful or painful events in your life? \_\_\_\_\_
  3. How would you describe your current level of stress? \_\_\_\_\_
  4. What is the impact of your breathing difficulties on your level of stress or anxiety?  
\_\_\_\_\_
  5. How has this affected your life? \_\_\_\_\_  
\_\_\_\_\_
  6. Have you been a victim of verbal, emotional, physical, or sexual abuse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- If yes, did you receive any counseling or assistance for the abuse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_