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____________________

12700 Hillcrest Road, Suite 276, Dallas, Texas 75230

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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 sough 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.)? ____