# 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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Name: ________________ Date: _______

| **Sensory Symptoms** (check all that apply) **(Recheck)** | Improved | Eliminated |
|---|---|---|
| ___ 1. Frequent throat clearing. ___Productive ___Non-Productive | _____ | _____ |
| ___2. Coughing | _____ | _____ |
| ___3. Progressive vocal fatigue. | _____ | _____ |
| ___ 4. Irritation or pain in the throat/back of throat. | _____ | _____ |
| ___ 5. Pressure in the chest. | _____ | _____ |
| ___ 6. Enlargement of neck muscles when speaking. | _____ | _____ |
| ___ 7. A feeling of a foreign substance or "lump" in throat. | _____ | _____ |
| ___ 8. Ear irritation, tickling, or earache. | _____ | _____ |
| ___ 9. Repeated sore throats. | _____ | _____ |
| ___ 10. A soreness or burning sensation in the throat (circle one). | _____ | _____ |
| ___ 11. Scratchy or dry throat. | _____ | _____ |
| ___ 12. A feeling that talking is an effort. | _____ | _____ |
| ___13. A choking feeling. | _____ | _____ |
| ___ 14. Tension and/or tightness in the throat. | _____ | _____ |
| ___15. Back or neck tension. | _____ | _____ |
| ___16. Headache. | _____ | _____ |
| ___ 17. Feeling of throat tightening when you speak. | _____ | _____ |
| **Auditory Symptoms** | | |
| ___ 1. Persistent hoarseness. | _____ | _____ |
| ___ 2. Reduced vocal range for speaking or singing. | _____ | _____ |
| ___ 3. Inability to talk at will and at length. | _____ | _____ |
| ___ 4. Repeated loss of voice. | _____ | _____ |
| ___ 5. Laryngitis. | _____ | _____ |
| ___ 6. Voice breaks. | _____ | _____ |
| ___ 7. Voice comes and goes during the day. | _____ | _____ |
| ___ 8. Missed speech sounds. | _____ | _____ |
| ___ 9. Clearer morning voice. | _____ | _____ |
| ___ 10. Voice gets better in afternoon or evening. | _____ | _____ |

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Name: ______________________ Date: ______________

1. Describe your voice problem, including approximate date of onset: ______________________

______________________________________________

Was the onset sudden or slow? ______________________________

2. Did your voice problem coincide with illness, a period of tension, excess pressure, excess talking or extra activity? Briefly describe: ______________________________

______________________________________________

3. Briefly describe your personality type, interests, etc. (ex: perfectionist, sports played, etc.) __________

______________________________________________

4. Which best describes your daily voice use (check one)? ___Excessive ___ Moderate ___ Minimal

Do you have to talk above noise? ___ no ___ yes If yes, describe: ______________________

Which best describes your telephone use (check one)? ___ Excessive ___ Moderate ___ Minimal

Do you talk in the car a great deal? ___ no ___ yes

5. Do you smoke? ______ If yes, how long and how much per day? ______________________

Have you used marijuana in the past year? ___ no ___yes

Do you use alcohol? ___ no ___ yes

Do you have allergies? ___ no ___ yes - describe:__________________

Do you have sinus problems? ___ no ___ yes – describe:__________________

6. Do you get regular exercise? ___ no ___ yes – describe:__________________

7. Generally speaking, do you sleep well? ___ no ___ yes

Do you fatigue easily? ___ no ___ yes

8. Please list any previous voice problems requiring medical or speech evaluation. ______________

______________________________________________

9. Prior speech therapy: ______________________________________

10. Surgeries in the past ten years: ______________________________

11. Current medication (continue on back if needed): ______________________________

______________________________________________