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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VOICE CASE HISTORY FORM

Patient's Name: _____

Patient's Date of Birth: _____ Age: _____

Insured's Name: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Address: _____

REFERRAL INFORMATION

Referred by: _____ Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ Diagnosis: _____

PATIENT'S MEDICAL HISTORY

Does the patient have allergies? ___ If yes, please describe: _____

Is the patient frequently around cigarette smoke? _____

Has the patient ever had chronic ear infections, sinus infections, colds, asthma, etc?

_____

_____

Has the patient ever had surgery or been hospitalized? _____ If yes, please describe:

_____

_____

Is the patient under a physicians care for any illness? _____ If yes, please describe:

_____

Is the student on medication? _____

If yes, please list medication: _____
_____

Has the patient ever been examined by an ENT? _____ What were the results?
_____
_____

Was a 2nd appointment scheduled? _____

Has the patient ever lost his/her voice? _____ How many times? _____

Does the patient ever complain of his/her throat burning? _____

Has the patient been diagnosed with reflux (GERD)? _____

Does the patient ever have heartburn? _____ Stomach Ache? _____

As an infant, did the patient have colic, spit up or upset stomach? _____

When was the patient's last hearing test and what were the results? _____
_____

Additional Comments: _____
_____
_____

STUDENT'S VOICE PROBLEM

Describe the voice problem: _____
_____

What do you think caused the problem? _____
_____

When did you first notice the problem?_____

Describe how the patient's voice sounds: _____
_____

Did the problem come on suddenly or gradually?_____
Has the problem become worse/better recently? _____

Does the patient's voice vary with different….

(A) Time of day _____
(B) Seasons or weather _____
C) Times of week _____

When is the voice the best? _____When is the voice the worst? _____

Does the patient talk excessively? _____

Does the student yell, scream, make vocal noises, or sing excessively? Please describe:
_____
_____

Does the patient cough or clear his throat frequently? _____

Has the patient demonstrated frustration with his/her voice problem? _____

Do you suspect the student uses his/her voice more frequently throughout the day compared to other children the same age? _____

Is the patient involved in school and community activities in which the voice is used excessively (cheerleading, athletics, drama, choir, etc.)? _____
_____
_____

Has the patient ever had speech therapy? _____If yes, please describe the problem:
_____
_____

Where did the patient attend therapy? _____

Clinician's Name: _____

Describe the patient's personality. Is he/she outgoing, shy, loud, quiet, etc?
_____
_____

FAMILY HISTORY

Does anyone in your family have a voice problem? _____

Has anyone in your family had speech therapy? _____
_____

Does the patient have any siblings? _____
If yes, please list names and ages: _____

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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.		_____	_____