ROCK
Therapeutic Services

Medical History

Name: _____ **Date of birth**: _____

Occupation _____

Family physician: _____

Referring physician: _____

Person filling out this form (circle one): self other: _____

What is your primary language? What other language do you speak?

Medical history: please check all that apply. Please provide the dates where applicable

- ☐ Heart attack
- ☐ Heart troubles
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ Chronic laryngitis
- ☐ Acid reflux
- ☐ Ear infections
- ☐ Meningitis
- ☐ Seizures
- ☐ Head injury
- ☐ Neurological conditions
- ☐ Allergies
- ☐ Cancer
- ☐ Head/neck cancer
- ☐ Shingles
- ☐ Bronchitis
- ☐ COPD
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Arthritis
- ☐ Hearing loss
- ☐ Cerebral palsy
- ☐ Intellectual deficits, MR
- ☐ Cleft palate
- ☐ Chronic colds
- ☐ Facial nerve palsy
- ☐ Emotional or psychological issues
- ☐ Multiple sclerosis
- ☐ Huntington's or Parkinson's Disease
- ☐ Voice issues or changes
- ☐ Vocal polyps or nodules

Any contractible diseases? i.e AIDS, HIV, HEP, etc.- If yes, please list all that apply.

What is your current state of health?

- ☐ Excellent
- ☐ Average-fair
- ☐ Poor

Have you been hospitalized within the last 5 years? If so, why? Where?

Please list any medications you are taking at this time:

SPEECH-LANGUAGE HISTORY

Symptom/Problem	Never	Sometimes	Frequently
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			
Voice difficulties			

Are there any other difficulties besides what is listed above?

When was this problem first noticed?

Did the problem begin suddenly or develop over time?

Have you been seen by any other rehabilitation professionals?

- ☐ **Speech therapy**: where: _____ when: _____
- ☐ **Physical Therapy**: where: _____ when: _____
- ☐ **Occupational Therapy**: where: _____ when: _____
- ☐ **Other**:

Does this speech-language difficulty impact your ability to function in daily life?

How or where does the speech-language difficulty impact you the most?

Describe your daily communication needs:

What do you hope to get out of speech-language therapy?

SOCIAL AND EDUCATIONAL HISTORY

1. Marital Status:

☐ Single ☐ Divorced

☐ Married ☐ Widowed

2. Spouse or partner's name: _____

3. Children:

Names	Ages

4. Do you currently work? _____ Yes _____ No

Occupation: _____

5. Employer: _____

6. Highest level of education (grade or degree) completed: _____

Please provide other information you believe to be helpful in the development of your therapy here with us at Rock Therapeutic Services. Thank you.

_____

Patient signature Date