Patient Information Form

Patient Information

Patient Name: ____ Date of Birth: ___/___/______ Age:__________

Last First MI mo day year

Gender: __________ Email Address: ____

Address: ______________________________ City: _________________ State:_______ Zip Code: ________

Cell Phone: _________________ Home Phone: ___________________ Work Phone: ___________________

Referred by: _____________________________ Primary Care Physician:_____________________________

Other specialists involved in care: ____

Primary reason(s) for today's visit: ____

____

Insurance Information

Person Responsible for Account: ____

Last First MI

Primary Insurance Company: ____

Subscriber's Name: ____________________________ Subscriber's Date of Birth: ______________________

Group Number: _________________________________ ID Number: _________________________________

Secondary Insurance Company:____

Subscriber's Name: ____________________________ Subscriber's Date of Birth: ______________________

Group Number: _________________________________ ID Number: _________________________________

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: ____Date:___________

Adult Auditory Processing Form

Patient Name: ____
Last *First* *MI*

Date of Birth: ___/___/______ Today's Date: ___/___/______ Patient's preferred hand: ☐ Right ☐ Left
mo day year *mo day year*

Primary Care Physician: ______________________ Referred by: ______________________

Primary Concern: ____

____

Please list those living in your home and their relationship to you: ______________________

____

Are you currently employed? YES ☐ NO ☐

Describe: ______________________

Are you currently a student? YES ☐ NO ☐

Highest level of education: ______________________

What are your hobbies and/or social activities? ______________________

Do your daily activities include:

- ☐ Giving presentations
- ☐ Listening to lectures
- ☐ Small group meetings
- ☐ Phone/video calls
- ☐ Phone/video conferences
- ☐ One-on-one meetings
- ☐ Working in a cubicle

Physical Health

YES	NO	
☐	☐	Are you taking any medications? If yes, please list: ______________________
☐	☐	Have you had any surgeries? If yes, please list: ______________________
☐	☐	Have you had any injuries? If yes, please list: ______________________
☐	☐	Do you have any concerns about your overall physical health? Explain: ______________________
☐	☐	Do you have any other diagnoses? (If yes, please provide a copy of reports if possible) ______________________

Family History

YES	NO	
☐	☐	Do you have a family history of hearing loss before age 40?
☐	☐	Do you have a family history of speech / language / communication / learning disorders? Please elaborate if "YES" to any of the above: ___________________________________

Hearing and Middle Ear History

YES	NO	
☐	☐	Have you been seen by an Ear, Nose, and Throat physician?
☐	☐	Have you been seen by an audiologist for a hearing assessment?
☐	☐	Do you have any allergies?
☐	☐	Do you have frequent colds or sinus infections?
☐	☐	Do you have a history of ear infections?
☐	☐	Did you ever have P.E. tubes placed?
☐	☐	Have you had ear pain?
☐	☐	Do you experience any dizziness?
☐	☐	Do you have any ringing in your ears?
☐	☐	Do you have any sensitivties to sound?

Behaviors and Characteristics of Auditory Processing Challenges

The following list has some common characteristics of auditory processing disorder.
Please check those items that are difficult for you:

☐ Listening in noisy environments?
☐ Listening for long periods of time?
☐ Multi-tasking?
☐ Spelling?
☐ Taking notes?
☐ Sarcasm and understanding jokes?
☐ Recognizing where a sound came from?
☐ Comprehending someone's intent (nonverbal cues)?
☐ Interpreting the main idea of a spoken narrative?
☐ Navigating social interactions?
☐ Processing information quickly and efficiently?

Speech and Language History- General

Have you received previous speech and language therapy? YES ☐ NO ☐

If yes, please explain (when, where, for how long):____

Do you speak more than one language? YES ☐ NO ☐

What languages do you speak? :____

Are there concerns regarding understanding others and expressing yourself clearly? YES ☐ NO ☐

If yes, please explain:____

Do you have concerns about your ability to:

YES	NO	
☐	☐	Think of the right words?
☐	☐	Participate in conversation?
☐	☐	Explain a process?
☐	☐	Talk about past and present events?
☐	☐	Express ideas concisely and clearly?
☐	☐	Use appropriate inflection in your voice?

Scale of Auditory Behaviors*

Please rate each item by checking the number that best fits the behavior of the person you are rating. The numbers correspond to the frequency with which the behavior is observed. Please consider these items carefully when rating each possible behavior. A person may or may not display one or more of these behaviors. A high rating in one or more of the areas does not indicate any particular pattern. If you are undecided about a particular item, use your best judgment.

Date: ______________________ Completed By: ______________________

Frequent	Often	Sometimes	Seldom	Never	Items
1	2	3	4	5	Difficulty hearing or understanding in background noise.
1	2	3	4	5	Misunderstands, especially with rapid or muffled speech.
1	2	3	4	5	Difficulty following spoken instructions.
1	2	3	4	5	Difficulty discriminating and identifying speech sounds.
1	2	3	4	5	Inconsistent responses to auditory information.
1	2	3	4	5	Poor listening skills.
1	2	3	4	5	Asks for things to be repeated.
1	2	3	4	5	Easily distracted.
1	2	3	4	5	Learning or academic difficulties.
1	2	3	4	5	Short attention span.
1	2	3	4	5	Daydreams, inattentive.
1	2	3	4	5	Disorganized.

Score (Clinician Use): ________

(For Adult & Ped. APD)
*SAB (Conlin, 2003, Schow et al. 2006, Shiffman, 1999: Simpson, 1981, Summers, 2003)
Adapted from the MAPA Assessment Manual

Systems History

Ears, Nose, Throat, and Mouth

EARS
❑ Hearing loss
❑ Consistent ear infections
❑ Placement of PE tubes (when? ___________)
❑ Skin tags or pits near the ears
❑ Struggle with hearing in noisy places
❑ **No concern**

NOSE
❑ Chronic congestion
❑ Frequent sinus infections
❑ Trouble breathing through nose
❑ **No concern**

THROAT
❑ Painful swallowing
❑ Pain or discomfort after talking
❑ Hoarseness
❑ Frequent throat clearing
❑ Feeling of something 'stuck' in throat
❑ **No concern**

MOUTH
❑ Oral habits (e.g. thumb sucking, use of pacifier, sucking on shirt strings)
❑ Difficulty transitioning to solids
❑ Difficulty chewing
❑ Coughing frequently while eating
❑ Constant dry mouth
❑ **No concern**
❑ Other:__________________________

Cardiovascular
❑ Chest pain or discomfort
❑ Shortness of breath with exertion
❑ **No concern**
❑ Other:__________________________

Psychiatric
❑ Anxiety or stress
❑ Depression
❑ Sleep problems
❑ **No concern**
❑ Other:__________________________

Vision

ACUITY
❑ Nearsighted
❑ Farsighted
❑ Astigmatism
❑ **No concern**

VISUAL PROCESSING
❑ Blurred vision
❑ Double vision
❑ Difficulty tracking
❑ Complaints of objects moving while trying to focus
❑ Dyslexia
❑ **No concern**
❑ Other:__________________________

Respiratory
❑ Asthma
❑ Apnea/Dyspnea
❑ Shortness of breath
❑ Frequent episodes of pneumonia, bronchitis, or other infections
❑ Trouble achieving adequate breath support
❑ **No concern**
❑ Other:__________________________

Neurological
❑ Dizziness
❑ Frequent headaches
❑ Weakness
❑ Tremors
❑ Seizures
❑ Memory loss
❑ Poor attention
❑ History of brain injury or concussions
❑ **No concern**
❑ Other:__________________________

Skin
❑ Rashes
❑ Acne
❑ Eczema
❑ **No concern**
❑ Other:__________________________

Musculoskeletal
❑ Muscle/joint pain
❑ Back pain
❑ Scoliosis
❑ **No concern**
❑ Other:__________________________

Gastrointestinal/ Genitourinary
❑ Heartburn or reflux
❑ Frequent nausea/ vomiting/ diarrhea
❑ Constipation
❑ Nighttime urination
❑ Kidney problems
❑ Struggle potty-training
❑ **No concern**
❑ Other:__________________________

Allergies
❑ Seasonal allergies
❑ Food allergies
Details: ___________________________
❑ Medication allergies
Details: ___________________________
❑ **No concern**
❑ Other:__________________________

Motor Development

FINE MOTOR
❑ Poor handwriting
❑ Trouble grasping small objects
❑ Trouble opening or closing screw-lid containers
❑ Trouble coordinating vision with hand movements (e.g. putting a puzzle together)
❑ **No concern**

GROSS MOTOR
❑ Trouble balancing
❑ Falls often
❑ Easily trips over objects
❑ **No concern**
❑ Other:__________________________

Previous Diagnoses
Please check all previous diagnoses.
❑ ADD
❑ ADHD
❑ Autism
❑ Asperger's Syndrome
❑ Cerebral Palsy
❑ Down Syndrome
❑ Mental Syndrome
❑ OCD
❑ **No concern**
❑ Other:__________________________

FOR AUDIOLOGIST'S USE ONLY

Otoscopic Inspection

RIGHT EAR

LEFT EAR

Active drainage observed	☐ YES	☐ NO
Visible Congenital or traumatic deformity	☐ YES	☐ NO
Visible evidence of significant cerumen	☐ YES	☐ NO
Air-bone gap of 15dB (.5, 1, or 2KHz)	☐ YES	☐ NO

Other pertinent information:

Summary:

Recommendations:

Medical Clearance: ____________________

Rescission Rights: ____________________

Physician Letter: Dr. ____________________

Hearing Instruments Initiated: ____________________

Additional Notes:

Audiologist Signature: ____________________ Reviewed:__________

For Speech Pathologist's use only. Areas assessed:

☐ Speech
☐ Oral mechanism

☐ Language
- Receptive
- Expressive

☐ Literacy
- Reading
- Writing

☐ Cognitive-Linguistics
☐ Fluency
☐ Voice

ESHC Evergreen Speech
& Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979
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Audiology • Hearing Testing • VRA • VNG/VEMP • OAE • BAER/ECochG • Hearing Aids • Cochlear/Bone Implants • Tinnitus • CAPD • EHDDI
Speech-Language Pathology • Language • Voice • Accent Modification • Autism • Evaluation & Treatment • Pediatric & Adults

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________________ Date of Birth:_______________

I acknowledge that I received a copy of Evergreen Speech & Hearing Clinic, Inc.'s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be post-ed in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Evergreen Speech & Hearing Clinic, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Evergreen Speech & Hearing Clinic, Inc may use and share my health information for other than treatment, payment, and health care operations.
- Evergreen Speech & Hearing Clinic, Inc. will also use and share my health informa tion as required/permitted by law.

______________________________________ ____________________
Printed name of patient or personal representative Date

______________________________________ ____________________
Signature of patient or personal representative Date

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