Evergreen Speech
& Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

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

# 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 Fluency History Form

Patient Name: ______________________________

Date of Birth: ______________________ Today's Date: ______________________

Primary Care Physician: ______________________ Referred by: ______________________

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

______________________________

**Primary Concern(s) for today's visit:** ______________________________

______________________________

### Health History

Please list any current or past conditions (illnesses, injuries or complications): ______________________

______________________________

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Are you taking any medications?<br>If yes, please list dosage and frequency: ______________________ |
| ☐ | ☐ | Is there a family history of speech, language, or learning problems?<br>If yes, please explain (include syndromes, dysfluencies/ stuttering, speech/ language impairments): ______________________ |
| ☐ | ☐ | Do you have any concerns about your hearing?<br>Date last tested and results: ______________________ |
| ☐ | ☐ | Do you have any concerns about your vision?<br>Date last tested and results: ______________________ |
| ☐ | ☐ | Do you have any allergies?<br>If yes, please describe: ______________________ |
| ☐ | ☐ | Do you have any other previous diagnoses? (e.g. autism, ADHD, dyslexia, etc.)<br>If yes, please describe: ______________________ |

### Vocation

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Are you currently employed?<br>If yes, what is your occupation? ______________________ |
| ☐ | ☐ | Are you currently a student?<br>If yes, where do you attend school? ______________________ |

Please describe how often you are required to speak at work and/ or school (i.e. for presentations, meetings, etc.): ______________________________

**Social History**

What language(s) is/ are spoken in your home?________________________________

What kinds of social activities do you participate in (i.e. church, book groups, clubs, etc.)? ________________

____________________________________________________

**Fluency and Stuttering**

When did your dysfluencies or stuttering first start or become noticeable? ______________________

Is there a family history of stuttering? YES ☐ NO ☐

If yes, please list family member:______________________________________

How does your family typically respond to your stuttering? _____________________________

____________________________________________________

How do your friends and/or co-workers typically respond to your stuttering? ______________________

____________________________________________________

Are there times you notice reduced stuttering? YES ☐ NO ☐

If so, when? ______________________________________________

Are there times when you notice increased stuttering? YES ☐ NO ☐

If so, when? ______________________________________________

Have you previously received speech therapy? YES ☐ NO ☐

If yes, when and for how long? ______________________________________

Was the treatment beneficial? Please elaborate. __________________________________

____________________________________________________

Please identify characteristics of your stuttering:

- ☐ Repeat parts of words (ca-ca-cat)
- ☐ Repeat whole words (my-my-my games)
- ☐ Interjections (um, like, you know)
- ☐ Block (often feels like words get stuck)
- ☐ Demonstrate tension in face or body
- ☐ Excessive or unusual eye blinking
- ☐ Excessive or unusual hand or body movements
- ☐ Avoid certain words
- ☐ Unusual changes in loudness or pitch
- ☐ Other: ____________________________________
- ☐ Repeat phrases
- ☐ Avoid eye contact
- ☐ Prolong sounds

Please circle your stuttering severity on a scale of 1-7 (1= no stuttering, 7= severe stuttering):

1 2 3 4 5 6 7

My goal for therapy is: ______________________________________________

____________________________________________________

Please provide any additional information that you feel may be relevant or that you'd like us to know. Your comments and opinions are very important. ______________________________________

____________________________________________________

____________________________________________________

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## Stuttering Handicap Index (SHI)

How would you complete the following questions?
Circle the number that best describes how you perceive your speech at this time.

| **A. How often do you stutter:** | **Never** | **Some-times** | **Half the time** | **Most of the time** | **Always** |
|---|---|---|---|---|---|
| With close family and friends? | 0 | 1 | 2 | 3 | 4 |
| With co-workers or acquaintances? | 0 | 1 | 2 | 3 | 4 |
| With strangers? | 0 | 1 | 2 | 3 | 4 |
| When tired? | 0 | 1 | 2 | 3 | 4 |
| When anxious or stressed? | 0 | 1 | 2 | 3 | 4 |
| When on the phone? | 0 | 1 | 2 | 3 | 4 |
| When in groups? | 0 | 1 | 2 | 3 | 4 |
| **B. How often do you:** | **Never** | **Some-times** | **Half the time** | **Most of the time** | **Always** |
| Avoid speaking or leave certain situations because you might stutter? | 0 | 1 | 2 | 3 | 4 |
| Not say what you want to say (i.e.change words, avoid words, don't respond to questions, change your word order to something easier to say)? | 0 | 1 | 2 | 3 | 4 |
| Think about your stuttering? | 0 | 1 | 2 | 3 | 4 |
| Feel your stuttering interferes with your goals? | 0 | 1 | 2 | 3 | 4 |
| Feel a lack of confidence in your speaking abilities? | 0 | 1 | 2 | 3 | 4 |
| **C. Because of your stutter, how often is it difficult for you to:** | **Never** | **Some-times** | **Half the time** | **Most of the time** | **Always** |
| Talk when there is time pressure? | 0 | 1 | 2 | 3 | 4 |
| Talk in front of a large group of people? | 0 | 1 | 2 | 3 | 4 |
| Talk on the telephone? | 0 | 1 | 2 | 3 | 4 |
| Start a conversation with people (i.e., introduce yourself)? | 0 | 1 | 2 | 3 | 4 |
| Participate in social events (i.e., make small talk at parties)? | 0 | 1 | 2 | 3 | 4 |
| Give oral presentations or speak in front of other people at work? | 0 | 1 | 2 | 3 | 4 |
| Talk with co-workers or other people at work (i.e., interact during meetings)? | 0 | 1 | 2 | 3 | 4 |
| Talk with your supervisor or boss? | 0 | 1 | 2 | 3 | 4 |
| **D. How much does stuttering interfere with your:** | **Never** | **Some-times** | **Half the time** | **Most of the time** | **Always** |
| Relationships with other people? | 0 | 1 | 2 | 3 | 4 |
| Sense of control over your life? | 0 | 1 | 2 | 3 | 4 |

For Clinic Use: ☐ Pre-Treatment ☐ Post-Treatment

*Totals:*

A. Frequency: ____________ C. Daily Communication: ____________ TOTAL: ____________

B. Reactions: ____________ D. Quality of Life: ________________ % CHANGE: ____________

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# 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 Speech Pathologist's use only.* Areas assessed:

- ☐ Speech
- ☐ Oral mechanism
- ☐ Language
  - Receptive
  - Expressive
- ☐ Literacy
  - Reading
  - Writing
- ☐ Cognitive-Linguistics
- ☐ Fluency
- ☐ Voice

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# 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 posted 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