ESHC 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 Speech History Form

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Other specialists involved in care: _____

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?
If yes, please list dosage and frequency: _____
_____

☐ ☐ Is there a family history of speech, language, or learning problems?
If yes, please explain (include syndromes, dysfluencies/ stuttering, speech/ language impairments): _____

☐ ☐ Do you have any concerns about your hearing?
Date last tested and results: _____

☐ ☐ Do you have any concerns about your vision?
Date last tested and results: _____

☐ ☐ Do you have any allergies?
If yes, please describe:_____

☐ ☐ Do you have any other previous diagnoses? (e.g. autism, ADHD, genetic syndrome, dyslexia, etc.)
If yes, please describe:_____

☐ ☐ Have you participated in speech therapy in the past?
If yes, When? For how long?_____
What did you work on?_____
Did it help? _____

☐ ☐ Have you participated in occupational or physical therapy in the past?
If yes, When? For how long?_____
What did you work on?_____
Did it help? _____

Swallowing

Describe any difficulties you have with swallowing, eating, or chewing: _____

_____

Please check any of the following that you experience:

- ☐ Throat clearing
- ☐ Loss of food from mouth onto chin or clothing
- ☐ Difficulty clearing food from mouth
- ☐ Difficulty drinking from cups or straws
- ☐ History of voice problems
- ☐ Difficulty swallowing pills
- ☐ Feeling that food is stuck in your throat
- ☐ Coughing during snack or meals
- ☐ No concern
- ☐ Other: _____

YES NO

☐ ☐ Are you on a special or restricted diet?
If yes, please describe: _____

☐ ☐ Have you had pneumonia?
If yes, please elaborate: _____

☐ ☐ Do you have asthma or chronic pulmonary disease?

Please list any other swallowing concerns: _____

_____

Vocation

YES NO

☐ ☐ Are you currently employed?
If yes, what is your occupation? _____

☐ ☐ Are you currently a student?
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.)? _____

_____

Speech and Language

Receptive Language ❑ NO CONCERN

YES NO

☐ ☐ Do you have difficulty understanding what others are saying to you?
If yes, please elaborate: _____

☐ ☐ Do you have difficulty following multi-step oral directions?

☐ ☐ Do you have to ask people to repeat themselves?

☐ ☐ Do you have difficulty listening in noise?

☐ ☐ Do you have difficulty understanding questions?

☐ ☐ Other:_____

Expressive Language ❑ NO CONCERN

Do you have concerns about your ability to:

YES NO

☐ ☐ Think of the right words?

☐ ☐ Use appropriate word order?

☐ ☐ Use appropriate grammar?

☐ ☐ Talk about events that will happen?

☐ ☐ Talk about events that already happened?

☐ ☐ Ask questions?

☐ ☐ Participate in conversation?

☐ ☐ Tell a story?

☐ ☐ Express feelings and opinions?

☐ ☐ Use specific words (versus overuse of words like “this”, “over there”, etc...)

☐ ☐ Other: _____

Articulation ❑ NO CONCERN

YES NO

☐ ☐ Do other people have difficulty understanding you?
If yes, please explain: _____

☐ ☐ Are there specific sounds that are more difficult for you to pronounce?
If yes, please explain: _____

☐ ☐ Do you have any weakness or difficulty moving your tongue, lips, or facial muscles?
If yes, please explain: _____

Fluency *(Stuttering/Stammering)*

Do you have any history of stuttering or stammering? Please describe:_____

_____

Pragmatics

Do you perceive any difficulty with social situations? YES ☐ NO ☐

Do you have difficulty with any of the following:

YES	NO	
☐	☐	Understanding humor?
☐	☐	Understanding people's intentions?
☐	☐	Understanding when people mean something different from what they say (sarcasm)?
☐	☐	Reading people's body language?
☐	☐	Figurative language (nonliteral language including idioms, metaphors, and abstract concepts)?
☐	☐	Identifying emotions in others?
☐	☐	Are you able to convey your own thoughts and intentions clearly?

Please list any situations when your communication challenges are worse:_____

_____

Please list any situations when your communication challenges are better: _____

_____

Please list any other speech/language concerns: _____

_____

Communication Rating Scale

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

0 = never; 1 = almost never; 2 = sometimes; 3 = almost always; 4 = always

Functional/Physical Domain	**Never**	**Almost Never**	**Some-times**	**Almost Always**	**Always**
I am unable to communicate effectively with others.	0	1	2	3	4
It is difficult for other people to understand me.	0	1	2	3	4
During conversation, my family complains that they do not understand me.	0	1	2	3	4
During conversation, unfamiliar listeners do not understand me.	0	1	2	3	4
On the phone, people ask me to repeat what I say.	0	1	2	3	4
When speaking face-to-face, people ask me to repeat what I say.	0	1	2	3	4
My speech is not accurately perceived by voice recognition software.	0	1	2	3	4
Others have commented that I speak differently.	0	1	2	3	4
I work very hard to be understood by others.	0	1	2	3	4
Activity & Participation Domain	**Never**	**Almost Never**	**Some-times**	**Almost Always**	**Always**
I communicate through text messaging or email to avoid speaking to others.	0	1	2	3	4
I speak with others less often becuase of my communication difficulty.	0	1	2	3	4
I tend to avoid speaking to goups of people because of my speech.	0	1	2	3	4
My communication skills prevent me from achieving my goals.	0	1	2	3	4
I am left out of conversations because of communication diffficulty.	0	1	2	3	4
I am less outgoing because of my communication difficulty.	0	1	2	3	4
My communication difficulty restricts my personal and social life.	0	1	2	3	4
My communication difficulty causes me to lost income.	0	1	2	3	4
My commnication difficulty limits my career advancement.	0	1	2	3	4
Emotional Domain	**Never**	**Almost Never**	**Some-times**	**Almost Always**	**Always**
I feel like no one understands my communication difficulty.	0	1	2	3	4
My communication problem frustrates me.	0	1	2	3	4
I feel irritated when others ask me to repeat myself.	0	1	2	3	4
I feel embarrassed when I am asked to repeat myself.	0	1	2	3	4
I feel ashamed of my communication difficulty.	0	1	2	3	4
I feel less confident about my skills as a communicator because of my difficulty.	0	1	2	3	4
I feel other people become frustrated when they do not understand me.	0	1	2	3	4
My communication difficulty makes me feel incompetent.	0	1	2	3	4
I feel my relationship with others is affected by my communication difficulty.	0	1	2	3	4

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 Clinician 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

Kirkland Office • 12333 NE 130th Lane, #430 • Kirkland, WA 98034 • 425.899.5050 Fax - 425.899.5054
Bellevue Office • 1800 116th Ave NE, #103 • Bellevue, WA 98004 • 425.454.1883 Fax - 425.454.2036
Redmond Office • 8301 161st Ave NE, #208 • Redmond, WA 98052 • 425.882.4347 Fax - 425.882.0043