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: _____

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Adult Voice History

Patient Name: _____
Last *First* *MI*

Date of Birth: _____ Today's Date: _____
mo day year *mo day year*

Primary Concern for today's visit: _____

_____

Date of Onset: _____ Sudden or Gradual? _____

What medical professionals, if any, have you consulted with regarding your concerns? _____

What are your goals for today's visit? _____

Please list other active treating providers (e.g. primary care physician, ENT, pulmonologist, psychologist, etc.)

Provider's Name: _____ Specialty: _____

Provider's name: _____ Specialty: _____

Provider's name: _____ Specialty: _____

Provider's name: _____ Specialty: _____

Health/Medical

Please list all current or past health conditions including dates and treatment: _____

_____

_____

Please list all past surgeries and hospitalizations and approximate dates:

Surgery	Date	Comments

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Do you have a history of allergies? Yes No

What are your triggers? _____

What are your symptoms? _____

What treatment have you received? _____

Have you ever experienced difficulty breathing or swallowing? Yes No

If so, please explain: _____

Do you have a history of reflux? Yes No

What are your triggers? _____

What are your symptoms? _____

What treatment have you received? _____

Do you frequently cough and/or clear your throat? Yes No

What are your triggers? _____

How does it impact your life? _____

Does anything help reduce the impact? _____

Are you currently taking medication? Yes No

Please elaborate, including dosage, and frequency: _____

_____

Are you currently taking vitamins/supplements? Yes No

Please elaborate, including dosage, and frequency: _____

_____

On average, how many hours of sleep do you get each night? _____

Approximately how many glasses of water do you drink daily? _____

Please describe your exercise routine (type, frequency): _____

_____

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Do you or have you ever used any of the following?

	Yes	No	Comments (dates, frequency, amount)
Tobacco Products			
Recreational Drugs			
Alcohol			
Caffeine			

Family & Social

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

_____

What languages are spoken in your home? _____

What activities do you participate in (e.g. church, book groups, sports, etc.)? _____

_____

Vocation

Are you currently employed? Yes No If so, where? _____

Are you currently a student? Yes No If so, where? _____

What is your current occupation/field of study? _____

Voice

Do you currently or have you ever used your voice in the following contexts/settings?

	Yes	No	Comments (dates, frequency)
Speaking on the telephone			
Speaking in noisy settings (e.g. restaurant)			
Speaking in one-on-one conversations			
Speaking in groups (e.g. lecture, meeting)			
Yelling or cheering			
Whispering			
Singing			

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Are you currently or have you ever been regularly exposed to any of the following?

	Yes	No	Comments (dates, frequency)
Smoke			
Chemicals (e.g. household cleaners)			
Allergens (e.g. dust, mold)			
Temperature changes (e.g. heat/AC)			

How often and in what capacity are you required to speak at work and/or school (e.g. meetings, projects presentations, etc.)? _____

_____

How often and in what capacity do you use your voice recreationally (e.g. singing lessons, standup comedy, acting, etc.)? _____

_____

Are you a vocal performer? Yes No

If so, please explain: _____

In what situations do you notice IMPROVED vocal quality (e.g. in the morning, with water, etc.)? _____

_____

_____

In what situations do you notice REDUCED vocal quality (e.g. changing of seasons, heightened emotion end of day, etc.)? _____

_____

Have you received voice therapy in the past? Yes No

If so, please explain: _____

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Please rate on a scale of 1-7 your vocal quality on a typical day (1-unable to use voice to communicate, 7-voice consistently sounds normal in all situations and contexts): _____

Please provide any additional information you feel may be relevant or that you would like for us to know. Your comments are very important to us! _____

_____

_____

_____

_____

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Voice Handicap Index

Check the response that indicates how frequently you have the same experience.

Part I-F	Never	Almost Never	Some-times	Almost Always	Always
1. My voice makes it difficult for people to hear me	0	1	2	3	4
2. People have difficulty understanding me in a noisy room	0	1	2	3	4
3. My family has difficulty hearing me when I call them throughout the house	0	1	2	3	4
4. I use the phone less often than I would like to	0	1	2	3	4
5. I tend to avoid groups of people because of my voice	0	1	2	3	4
6. I speak with friends, neighbors, or relatives less often because of my voice	0	1	2	3	4
7. People ask me to repeat myself when speaking face-to-face	0	1	2	3	4
8. My voice difficulties restrict personal and social life	0	1	2	3	4
9. I feel left out of conversations because of my voice	0	1	2	3	4
10. My voice problem causes me to lose income	0	1	2	3	4
Part II-P	Never	Almost Never	Some-times	Almost Always	Always
1. I run out of air when I talk	0	1	2	3	4
2. The sound of my voice varies throughout the day	0	1	2	3	4
3. People ask, “What’s wrong with your voice?”	0	1	2	3	4
4. My voice sounds creaky and dry	0	1	2	3	4
5. I feel as though I have to strain to produce voice	0	1	2	3	4
6. The clarity of my voice is unpredictable	0	1	2	3	4
7. I try to change my voice to sound different	0	1	2	3	4
8. I use a great deal of effort to speak	0	1	2	3	4
9. My voice is worse in the evening	0	1	2	3	4
10. My voice “gives out” on me in the middle of speaking	0	1	2	3	4
Part III-E	Never	Almost Never	Some-times	Almost Always	Always
1. I am tense when talking to others because of my voice	0	1	2	3	4
2. People seem irritated with my voice	0	1	2	3	4
3. I find other people don’t understand my voice problem	0	1	2	3	4
4. My voice problem upsets me	0	1	2	3	4
5. I am less outgoing because of my voice problem	0	1	2	3	4
6. My voice makes me feel handicapped	0	1	2	3	4
7. I feel annoyed when people ask me to repeat	0	1	2	3	4
8. I feel embarrassed when people ask me to repeat	0	1	2	3	4
9. My voice makes me feel incompetent	0	1	2	3	4
10. I am ashamed of my voice problem	0	1	2	3	4

For clinic use:

Voice Handicap Index: Part I-F _____ Part II-P _____ Part III-E _____ **Total** _____

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Eating Assessment Tool (EAT-10)

Within the **past month,** to what extent have the following scenarios problematic for you? Circle the appropriate response.

	No problem				Severe Problem
My swallowing problem has caused me to lose weight.	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals.	0	1	2	3	4
Swallowing liquids takes extra effort.	0	1	2	3	4
Swallowing solids takes extra effort.	0	1	2	3	4
Swallowing pills takes extra effort.	0	1	2	3	4
Swallowing is painful.	0	1	2	3	4
The pleasure of eating is affected by my swallowing.	0	1	2	3	4
When I swallow food sticks in my throat.	0	1	2	3	4
I cough when I eat.	0	1	2	3	4
Swallowing is stressful.	0	1	2	3	4
For staff input only EAT-10 Scores:					

Reflux Symptom Index (RSI)

Within the B, how did the following symptoms affect you? Please rate each item below on how "bad" it is (that is, the amount of each problem that you have). Use the following scale for rating the amount of the problem:

	No problem					Always
1. Hoarseness or a problem with your voice?	0	1	2	3	4	5
2. Clearing your throat?	0	1	2	3	4	5
3. Excess throat mucus or postnasal drip?	0	1	2	3	4	5
4. Difficulty swallowing food, liquids or pills?	0	1	2	3	4	5
5. Coughing after you ate or lie down?	0	1	2	3	4	5
6. Breathing difficulties or choking episodes?	0	1	2	3	4	5
7. Troublesome or annoying cough?	0	1	2	3	4	5
8. Sensations of something sticking in your throat or a lump in your throat?	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up?	0	1	2	3	4	5
For staff input only RSI Score:						

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Treatment A/V Authorization Form

Name of the person in treatment:_____

During your or your treatment sessions your speech-language pathology team may wish to use audio or visual (A/V) recording for further analysis, communication between treating clinicians, progress documentation, grand rounds session and/or educational purposes. This material will not be used for marketing, advertisement, or external communications without further consent.

Please check a box below to indicate if A/V recordings can be used during treatment session.

E vergreen Speech & Hearing Clinic **has my permission** to use A/V recordings during therapy sessions.
E vergreen Speech & Hearing Clinic **does not have my permission** to use A/V recordings during therapy sessions.

_____

Signature Date

If under 18, a parental or guardian signature is required

_____

Parental/Guardian Signature Date

_____

Speech-Language Pathologist Signature Date

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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

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