MAIA C. KING, M.S., CCC-SLP, PLLC

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*DATE OF EVALUATION:_____ ****Kindly cancel 24 hours in advance****_*

First Name: _____ Last Name:_____

Date of Birth: _____ Is this a home visit? Y/N Do you have any animals:_____

List all languages that you speak?_____ What is the dominant language _____

Emergency Contact (list 2) and Name phone number_____ _____

Occupation: _____Insurance Primary :_____ 2ndary _____

Address:

MD/DENTIST	SPECIALTY	PHONE	ADDRESS/LOCATION
1.			
2.			
3.			
4.			
5.			
6.			

oReason for Referral: _____

Have you ever had Speech Therapy before? Y/N Date of last evaluation _____

Frequency and duration of last episode (2x for 6 weeks) _____

***MEDICARE PART B CLIENTS ONLY –** Are you receiving Physical therapy or Occupational Therapy? Y/N _____ Please list the date of the evaluation: _____
Please provide the frequency for each discipline _____
Please **INDICATE WHICH** days you are receiving **Physical Therapy** below
_____MON _____TUES_____WED____THURS____FRI____SAT ____SUN____

***PLEASE BE AWARE I CANNOT SCHEDULE YOU THE ON THE SAME DAY AS PT!!!!!**

_____

* HEALTH HISTORY

Describe your present health_____

Have you ever been to a Neurologist? Explain if yes _____

*PLEASE EXPLAIN

_____

_____

Please provide the diagnosis: _____

Is there a history of: CVA/STROKE, TBI, BRAIN TUMOR DEMENTIA/ALZHEMIERS/ APHASIA, PARKINSON'S DISEASE, MS, ALS, HEAD AND NECK CANCER?

_____

_____

CHECK OFF BELOW THAT APPLY; IF NONE SKIP

Numbness ___ ___ Paralysis/Paresis ___ ___

Chronic Sinus Infections _____
Asthma ___ ___ In coordination of the face or tongue/ muscles ___ ___
Broken Nose ___ ___ Bronchitis ___ ___ Mouth- Breathing ___ ___
Chronic Colds ___ __ Pneumonia ___ ___
Chronic Laryngitis ___ __ Physical defect ___ ___
Chronic Rhinitis ___ ___ Clef Palate ___ ___
Poliomyelitis ___ ___ Ear Disease ___ ___
Rheumatic Fever ___ ___Scarlet Fever ___ ___
Hearing Problem ___ ___ COPD ____ _____
Psychological
Tremor/Twitching ___ ___
Hyperthyroidism ___ ___ Visual Problem ___ ___
Hypothyroidism ___ ___ Hormone therapy ___ ___
Whooping Cough ___ ___ Heart Trouble ___ ___
Hypertension ___ ___ Acid Reflux_____

If the answer to any of the above items is "Yes" give relevant details:_____

_____

_____

Please list any/and or all hospitalizations, procedures, surgeries etc; if none skip.

_____

Date of recent hospitalization: _____ Date of sub-acute admission _____

Date of Discharge: _____ _____ _____ _____

Swallowing

Are there any known difficulties with swallowing ? Y/N

Is there a history of a swallowing disorder or Dysphagia? Y/N

Has your diet ever been restricted (e.g., soft foods, thickened liquids) Y/N? Please explain if you answered yes::

_____
_____

Are there any concerns with nutrition, hydration, failure to thrive or limited intake of fluids and/or meal consumption? Y/N Please explain if you answered yes:

_____
_____

Do you have difficulty with your teeth? Y/N Are you currently under the car of a dentist? How would you describe your level of oral care (poor, fair, good, excellent)

Do you wear dentures? Y/N Do they fit properly? Y/N/

*Please provide the name of your dentist at the top of page one if you have answered YES to any of the above listed questions.

Is there a history of COPD? Y/N Have you ever had Pneumonia or Aspiration Pneumonia? Y/N _____

Please explain if you answered yes and how long ago_____

_____

Do you receive the pneumonia vaccination? Y/N _____

Do you feel anything stuck in your throat after eating and drinking, swallowing pills? Y/N _____

Do you feel short of breath after drinking? Y/N

Do you cough, clear your throat, have a change in vocal quality after eating or drinking? Y/N _____
*PLEASE EXPLAIN

Do you have acid reflux? Y/N _____ Is it under control ? _____

VOICE

Please check off all that apply to describe your voice

Voice pitch too high____ Voice pitch too low____ Voice too loud____

Voice too soft____ Frequent pitch break ____ Infrequent pitch break ____
Harsh____ Hoarse____ Nasal____

Breathy____
Monotonous____ Difficulty controlling voice____

Do you feel there is a problem with your voice? Y/N

What are some of your goals for speech therapy?

Please check off preference for treatment days. I will do my best to accommodate you!

_____MON ____ TUES____WED_____THURS_____FRIDAY_____SAT_____SUN

Time Range 10-12_____ 12:30-2_____3-5_____

*if I am traveling to your house please allow a 30 min time range for travel!