Date: _____ **SPORTS REHAB AND PROFESSIONAL THERAPY ASSOCIATES**

Time: _____ **SPEECH THERAPY OUTPATIENT QUESTIONNAIRE**

Person completing form: _____

Name: _____ Birth date:_____ Age:_____ Male / Female

Address :(street) _____ (town)_____ (zip)_____

Medicare#_____ Referring Doctor:_____

Diagnosis: _____ Education: _____

1. For what reason were you referred to speech therapy? _____
2. When did this problem start? _____ How long have you had this problem? _____

   What was the cause? _____
3. List any language fluently spoken other than English?_____
4. What specific tasks at work have been affected?_____
5. What have you done to treat the condition at home? _____
6. Have you had this problem before? _____
7. Have you had physical, occupational, or speech therapy before?_____
8. Has this problem affected your home, social, or work life? Yes or No (please circle) If yes, please explain_____
9. Has your family or friends noticed any changes? Yes or No (please circle) If yes, what have they noticed?

   _____
10. Do you have any problems at school? Yes No N/A If yes, please explain

    _____

Health History

1. Have you been exposed to a contagious disease or infection in last 4 weeks? Yes or No
2. Do you have any contagious disease or infection? Yes or No If yes, please circle below:

Hepatitis HIV AIDS VRE MRSA TB Shingles Other:_____

3. Have you had any x-rays for this condition?_____
4. What medications are you taking for condition?_____
5. Are you taking any medications on a daily basis? Yes or No List: _____
6. Do you have any other medical problems?_____
7. Do you have allergies? _____
8. Have you had any recent surgeries? _____
9. Do you have a pacemaker? _____

*List any additional information which may be helpful in assisting with your problem: