

## Speech & Language Evaluation Information

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Primary Doctor \_\_\_\_\_ Clinic \_\_\_\_\_  
Person completing form \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Telephone # \_\_\_\_\_ E-mail \_\_\_\_\_

### Evaluation Considerations

What concerns do you have? Please check all that apply:

- Articulation (speech sounds)    Fluency (stuttering)    Voice  
 Language    Swallowing    Cognition    Non verbal  
 Other: \_\_\_\_\_  
\_\_\_\_\_

### Medical History

Please check all past or current medical conditions that apply:

- Hearing loss    Suspected hearing loss    Cochlear implants    Feeding tube  
 Stroke/CVA    Traumatic Brain Injury    Dysphagia    Depression    Anxiety  
 Seizure disorder  
 Other: \_\_\_\_\_

### Health History:

Please indicate current or past problems in the following areas:

- |  |                 |
|--|-----------------|
| Vision: <input type="radio"/> Yes <input type="radio"/> No               | Comments: _____ |
| Hearing: <input type="radio"/> Yes <input type="radio"/> No              | Comments: _____ |
| Sensation: <input type="radio"/> Yes <input type="radio"/> No            | Comments: _____ |
| Communication: <input type="radio"/> Yes <input type="radio"/> No        | Comments: _____ |
| Heart: <input type="radio"/> Yes <input type="radio"/> No                | Comments: _____ |
| Breathing: <input type="radio"/> Yes <input type="radio"/> No            | Comments: _____ |
| Digestion: <input type="radio"/> Yes <input type="radio"/> No            | Comments: _____ |
| Circulation: <input type="radio"/> Yes <input type="radio"/> No          | Comments: _____ |
| Emotional: <input type="radio"/> Yes <input type="radio"/> No            | Comments: _____ |
| Pain: <input type="radio"/> Yes <input type="radio"/> No                 | Comments: _____ |
| Bone / Joint: <input type="radio"/> Yes <input type="radio"/> No         | Comments: _____ |
| Muscular: <input type="radio"/> Yes <input type="radio"/> No             | Comments: _____ |
| Thinking / Cognition: <input type="radio"/> Yes <input type="radio"/> No | Comments: _____ |

Does the patient have any other medical condition(s) or allergies?  No    Yes

Please list: \_\_\_\_\_

Has the patient recently been hospitalized or had any medical procedures?  No    Yes

Please list: \_\_\_\_\_

Is the patient currently taking any medications?  No  Yes (Please list):

Medication	Dose/Frequency	What it treats

Are there any other precautions or restrictions that I should be aware of?  No  Yes (Describe):

\_\_\_\_\_

Please list any current medical conditions or diagnoses that the patient has been given:

\_\_\_\_\_

Is the patient currently under the care of any of the following specialists?: (Check all that apply)

- Cardiologist  Audiologist  ENT  Psychiatrist  Psychologist  Pulmonologist  
 Endocrinologist  Geneticist  Physical Therapist  Occupational Therapist  Neurologist  
 Other: \_\_\_\_\_

Do you give consent to Kim Lemley, M.S. CCC-SLP to discuss your evaluation or treatment with any of the specialists listed above? If so, please provide the names of all specialists that you give consent to release information to: \_\_\_\_\_

\_\_\_\_\_

**Educational Information:**

Highest level of education:  Some Highschool  Highschool  Some college

College degree  Professional degree  Technical degree  Other (Please describe):

\_\_\_\_\_

Does the patient receive any of the following services?

Speech Therapy: \_\_\_\_\_ times a week  Occupational Therapy: \_\_\_\_\_ times a week

Physical Therapy: \_\_\_\_\_ times a week

Do you give your consent to Kim Lemley, M.S. CCC-SLP or another member of the Pitts & Associates staff to discuss your evaluation and/or treatment with your other therapist(s) \*if applicable?  No  Yes  
If so, please list: \_\_\_\_\_

**Additional Information:**

Has the patient ever been evaluated for speech therapy before?  No  Yes

In therapy, the patient is working on: \_\_\_\_\_

Is there any other additional information I need to know?

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**Authorization to test and/or treat**

I authorize Kim Lemley, M.S. CCC-SLP, to evaluate and treat  
\_\_\_\_\_ (patient name).

I understand that I will be responsible for payment at the time of service, as well as a possible fee for missed visits and late cancellations. I authorize communication between Kim Lemley or a billing specialist from Pitts & Associates and my insurance company for coordination of payment. I authorize verbal and written communication between Kim Lemley and my medical doctor for coordination of care.

\_\_\_\_\_  
Patient or caregiver signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Caregiver printed name