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: ◯ Yes ◯ No Comments: _____
Hearing: ◯ Yes ◯ No Comments: _____
Sensation: ◯ Yes ◯No Comments: _____
Communication: ◯ Yes ◯ No Comments: _____
Heart: ◯ Yes ◯ No Comments: _____
Breathing: ◯ Yes ◯ No Comments: _____
Digestion: ◯ Yes ◯No Comments: _____
Circulation: ◯ Yes ◯ No Comments: _____
Emotional: ◯ Yes ◯ No Comments: _____
Pain: ◯ Yes ◯ No Comments: _____
Bone / Joint: ◯ Yes ◯ No Comments: _____
Muscular: ◯ Yes ◯ No Comments: _____
Thinking / Cognition: ◯ Yes ◯ 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?

_____
_____
_____

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