Active Development Therapies, LLC

Adult Medical History Questionnaire-SLP

Patient Name_____ Date of Birth:_____
Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employed? ☐Yes ☐No Employer:_____
Are you currently working? ☐Yes ☐No What is your occupation?_____
Current Residence: Who do you live with?_____
Are they able to assist you with daily living activities, if needed? ☐Yes ☐No

Date of Onset/Injury:_____ Have you had these symptoms before? ☐Yes ☐No
Have you been given a specific diagnosis(es) related to your symptoms? ☐Yes ☐No

If so, what?_____
Check all that apply to your current symptoms: ☐Work-Related Injury ☐Motor Vehicle Accident
☐Reoccurrence of previous/old injury ☐Sports-Related Injury ☐Swallowing Difficulties
☐Neurological-Related Injury/Issues ☐Degenerative Disorder ☐Cause Unknown
☐Communication Difficulties ☐Other:_____

Have you had a surgery related to your current issues? ☐Yes ☐No When?_____

Surgical intervention(s) performed?_____

Do you currently have or have had in the past any of the following medical conditions?

☐Heart Disease	☐Heart Attack	☐Heart Palpitations	☐Hearing Loss
☐Heartburn/Reflux/GERD	☐High Blood Pressure	☐High Cholesterol	☐Stroke ☐Asthma
☐TIA/Mini-Stroke	☐Anxiety Disorder	☐Depression	☐Fibromyalgia
☐Lung Disorders/Problems	☐Thyroid Disease	☐Dizziness/Fainting	☐Seizures/Epilepsy
☐Chronic Headaches/Migraines	☐Nausea/Vomiting	☐Gallbladder/Liver Issues	☐Tinnitus
☐Bowel/Bladder Abnormalities	☐Vertigo	☐Mastoiditis	☐Fever(s)
☐Encephalitis	☐Pneumonia	☐Tonsillitis	☐Otosclerosis
☐ Motion Sickness/Sensitivity	☐Bursitis	☐Cellulitis	☐Meningitis
☐Vision Impairments/Disorder	☐Blood Disorder	☐Ulcers/Stomach Problems	☐Hernia
☐Arthritis; Type?_____		☐Diabetes; Type?_____	☐Known Allergies
☐Orthopedic Problems	☐Skin Issues	☐Loss of Consciousness	☐Pregnant
☐Fractures; Type?_____		☐Ear Pain/Problems	☐Dysphagia
☐Cancer; Type?_____			
☐Traumatic Brain Injury/Head Injury		☐Injury; Type?_____	
☐Other:_____			

If you marked any medical conditions above that need further explanation, please list below:_____

_____

_____

Is there familial history of any conditions indicated above? ☐Yes ☐No Who?☐Paternal ☐Maternal
☐Mother ☐Father ☐Sibling ☐Grandparent ☐Uncle ☐Aunt ☐Offspring
Have you ever had any surgical procedures? ☐Yes ☐No If so, what procedures were performed?_____

_____

Have you ever had any of the following?☐X-Ray☐CT Scan☐MRI☐EMG☐EEG☐ECG☐Spinal Tap☐Other
Have you had any illness within the past month? ☐Yes ☐No With?_____

What is your current: Height?_____ Weight?_____

Current Lifestyle Trends: ☐Drink Coffee; How much?___ ☐Drink Tea; How much?___ ☐Smoke; How much?___
☐Drink Soda; How much?_____ ☐Drink Alcohol; How much?_____ ☐Have Healthy Diet Overall
☐Exercise; How often?___; What type?_____ ☐Have Special Diet Restrictions; What?_____

Do you have any special needs/concerns that your therapist should be aware of (i.e. vision, hearing, communication, cognitive, physical limitations, sensitivities, environmental concerns, etc)? ☐Yes ☐No
Please list any needs/concerns if indicated YES:_____

Current Issues:
Please describe your current symptoms:_____

When did these symptoms begin? Year(s)_____ Month(s)_____
How did your symptoms start? ☐Gradually ☐Suddenly ☐Affected limited areas ☐Affected me globally
Since beginning, your symptoms have? ☐Improved ☐Remained the Same ☐Worsened
Are your symptoms consistent or do they vary? ☐Yes ☐No
Do you notice certain circumstances that create fluctuations or variations in your symtpoms? ☐Yes ☐No
If so, what?_____
Have you ever been seen by another professional for the current issue? ☐Yes ☐No
If so, what did they suggest?_____
What are you hoping to result from this evaluation?_____

Dizziness, Vertigo, Lightheadedness Questions
Do your symptoms include dizziness? ☐Yes ☐No
Does anything help this feeling? ☐Yes ☐No What?_____
Does anything make this feeling worse? ☐Yes ☐No; What?_____
Does anything precipitate an attack? ☐Yes ☐No; What?_____
How often do attacks occur?_____ How long do they last?_____
Do you ever have a warning of an attack? ☐Yes ☐No; Describe:_____
Were you exposed to irritating or noxious fumes, chemicals, etc at the onset of dizziness? ☐Yes ☐No
Do you ever have a spinning sensation? ☐Yes ☐No
Are objects spinning around you? ☐Yes ☐No OR Are you spinning around objects? ☐Yes ☐No

Check all that applies to your dizziness, vertigo, or lightheadedness: ☐Better if you sit or lay perfectly still
☐Get Nauseated and/or Vomit ☐Affected when you haven't eaten for a long time ☐Lightheadedness
☐Always fall to one side ☐Free from symptoms between attacks ☐Black Out/Faint
☐Dizzy or Unsteady constantly ☐Affected when you stand up too quickly ☐Swimming sensation
☐Affected when lying down ☐Trouble walking in the dark
☐Affected in certain positions; which?_____
☐Other:_____

Check all other sensations that you typically have: ☐ Tingling around the mouth ☐Pressure in your head
☐Double, blurry, or jumping vision ☐Slurred or difficult speech ☐Getting easily upset
☐Numbness in face or extremities ☐Jerking of arms and/or legs ☐Difficulty Swallowing
☐Weakness or faintness a few hours after eating ☐Confusion or memory loss ☐Weakness/Clumsiness

Check all that are linked to your dizziness: ☐Headaches ☐Stress ☐Menstrual Cycle
☐Recent changes in eyeglasses ☐Overwork/Exertion ☐Diet ☐Rapid Motion
☐Position Changes

Indicate difficulties with your ability to function in your daily life independently:
☐Frequent illnesses: How many? ☐within last year____ ☐within last 6 mos____ ☐within last month__
☐Difficulty communicating needs ☐Frequent coughing or choking with: ☐foods ☐liquids ☐medications
☐Difficulty being understood when speak ☐Difficulty comprehending the speaker ☐Difficulty hearing
☐Stuttering/Dysfluency ☐Memory Loss ☐Difficulty speaking for long periods of time

Communication Questionnaire: **If there are no concerns with communication, please skip to next section.**
Describe your concerns about your communication:_____
_____
_____
_____
How long have you been concerned about your communication skills? Years_____ Months_____
What do you think is the cause of your communication issues?_____
What sounds or words that are most difficult to say?_____
Are there times when your speech seems slurred? ☐Yes ☐No
Are there times of the day when your speech is better than others? ☐Yes ☐No
If so, when?☐Morning ☐Mid-Day ☐Late Afternoon ☐Night ☐Other:_____
Are you able to be understood by your family members? ☐Yes ☐No
Are you able to be understood by strangers? ☐Yes ☐No
Are you able to be understood when talking in: ☐a quiet environment ☐on the telephone ☐in a car
☐in a crowded/public place ☐in a group
Are you asked to repeat yourself? ☐Yes ☐No How often?_____
Does your speech affect your interactions with others or participation in activities? ☐Yes ☐No

Language Comprehension and Expression Questionnaire:
If there are no concerns with language, please skip to next section.
What is your native/primary language?_____
Do you speak any other languages? ☐Yes ☐No If so, which?_____
Are you having difficulty in your native language *and* English? ☐Yes ☐No
How long have you been concerned about your language? Years_____ Months_____
Who first noticed the problem?_____
Describe your concerns about your language:_____
_____
_____
_____
Do you ever forget the word you are trying to say? ☐Yes ☐No
Do you ever lose train of thought or skip quickly between topics? ☐Yes ☐No
Do you ever have difficulty following/understanding a conversation? ☐Yes ☐No
Are you able to understand and answer questions? ☐Yes ☐No
Are you able to follow directions? ☐Yes ☐No Multi-level directions? ☐Yes ☐No
Are you able to follow conversation when there is distraction or background noise involved? ☐Yes ☐No
What do you think is the cause of your language issues?_____
Has this improved over time? ☐Yes ☐No Has this worsened over time? ☐Yes ☐No
Do you read? ☐Yes ☐No How often?_____ What type of books?_____
What is your highest level of education? ☐Elementary ☐Junior High ☐High School/GED
☐Associate's Degree ☐Master's Degree ☐Doctorate or Post-Doctorate Degree

Did you have any problems learning? ☐Yes ☐No; What?_____
Does your language affect your interactions with others or participation in activities? ☐Yes ☐No
What have you done to try and improve your language skills?_____

Stuttering/Dysfluency Questionnaire: **If there are no concerns with stuttering, please skip to next section.**
Describe your speech when you stutter:_____
_____
_____
_____
_____
When did you first begin to stutter? Age_____
Who noticed that you had dysfluent speech?_____
In what type of speaking situation was it first noticed in?_____
Do you have a family history of stuttering? ☐Yes ☐No Who?_____
Do they still stutter? ☐Yes ☐No Did they receive treatment for stuttering? ☐Yes ☐No
Why do you think you stutter?_____
_____
Does the stuttering bother you? ☐Yes ☐No How?_____
_____
How do others (family, friends, strangers, etc) react to your stuttering?_____
_____
In what situations do you stutter <u>most</u>? ☐everyday conversation ☐speaking in or to a large group
☐over the telephone ☐speaking to family members ☐speaking to strangers ☐speaking to friends
☐speaking to co-workers/supervisors ☐speaking to authority figures ☐speaking to child/children
☐reading aloud in front of others ☐low stress situations ☐high stress situations
In what situations do you stutter <u>least</u>? ☐everyday conversation ☐speaking in or to a large group
☐over the telephone ☐speaking to family members ☐speaking to strangers ☐speaking to friends
☐speaking to co-workers/supervisors ☐speaking to authority figures ☐speaking to child/children
☐reading aloud in front of others ☐low stress situations ☐high stress situations
Does your stuttering give you difficulties at: ☐Home ☐School ☐Work ☐Other:_____
Do you notice yourself avoiding certain speaking situations? ☐Yes ☐No
Describe:_____
_____
Do you notice yourself avoiding certain sounds or words? ☐Yes ☐No
Describe:_____
_____
Does your stuttering vary from day to day? ☐Yes ☐No How and Why?_____
_____
_____
What have you done to try and eliminate your stutter?_____
_____
_____
If therapy, with whom, where, and what were the results?_____
_____
_____
Have you had any illnesses or accidents that seemed to affect your speech? ☐Yes ☐No
If so, describe:_____
_____

Is your speech typical today as it is most days? ☐Yes ☐No
Is it better or worse than normal? ☐Better ☐Worse How?_____

Voice Questionnaire: **If there are no concerns with your voice, please skip to next section.**
Describe your concerns with your voice:_____
_____
_____
_____
How long have you noticed this problem? Years_____ Months_____
Who first noticed the voice problem?_____
Describe, if different than above, your voice problem when it was first noticed:_____
_____
_____
How has this changed over time? ☐Improved ☐Remained the Same ☐Worsened
What do you think is the cause of your voice issues?_____
Do you speak a lot: ☐at home? ☐at work? ☐on the telephone? ☐at social events? ☐in large groups?
What types of activities are you involved in?_____
_____
Do you ever run out of breath when you speak? ☐Yes ☐No
Describe those situations:_____
_____
In what speaking situations is your voice the BEST?_____
_____
In what speaking situations is your voice the WORST?_____
_____
Are there times of the day that your voice is better or worse? ☐Yes ☐No (indicate with B &/or W below)
Morning____ Mid-Day____ Afternoon_____ Evening____ Night____
How does others react to your voice problem:
Family?_____
Friends/Acquaintances?_____
How does your voice affect your interactions: At home?_____
At work?_____; At school?_____
Speaking to others?_____; In community?_____
Have you ever tried anything to resolve this problem? ☐Yes ☐No How?_____
_____
Have you ever seen an Ear, Nose, and Throat specialist? ☐Yes ☐No What was the outcome?_____
_____
Have you ever been treated by a Speech-Language Pathologist for this issue? ☐Yes ☐No For how long and what were the results?_____
Have you ever noticed any illnesses or accidents that seem to affect your voice? ☐Yes ☐No
Describe:_____
Is your voice typical today as it is most days? ☐Yes ☐No
Is it better or worse than normal? ☐Better ☐Worse How?_____

Do you have any pain with your difficulties/disorder, if so please rate the intensity of your pain on a scale of 1 to 10. **(0=no pain; 10=extreme/worst pain)**
With your current symptoms?
0 1 2 3 4 5 6 7 8 9 10

When your symptoms are at their worst level?

0 1 2 3 4 5 6 7 8 9 10

When your symptoms are at their best level?

0 1 2 3 4 5 6 7 8 9 10

Please use the diagram below to illustrate where and what the symptoms for which you are coming to therapy. Shade in the area for pain with the following:

XXXXX = numbness & tingling; 00000 = pins and needles; ///// = stabbing;
SSSSS = burning; ZZZZZ = deep ache