



**SPEECH THERAPY INTAKE**

CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601

Date: \_\_\_\_\_

**WELCOME TO OUR CLINIC.** To assist in your care, please fill out or circle the answers as best you can.

**PATIENT NAME:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** Male / Female

Referring Physician: \_\_\_\_\_ PCP: \_\_\_\_\_

Primary Language: \_\_\_\_\_ English Understood ☐ YES ☐ NO Interpreter Needed: ☐ YES ☐ NO

Email: \_\_\_\_\_

Person filling out this form: ☐ Self ☐ Other \_\_\_\_\_

Describe why you are here (injury, surgery, or onset of symptoms): \_\_\_\_\_

☐ New onset ☐ Recurring ☐ Worsening ☐ Improving Date symptoms began: \_\_\_\_\_

Do you use any of the following assistive devices?

☐ Wheelchair ☐ Walker ☐ Cane ☐ Hearing Aids ☐ Glasses/Corrective Lenses

Are you currently on oxygen? ☐ YES ☐ NO If YES, how many liters and how often? \_\_\_\_\_

**Setting goals is necessary to help with treatment and justify medical need. Your input is essential.**

Please list any activities that you are currently unable to do because of your injury/illness: \_\_\_\_\_

**Please state your goal(s) for therapy:** \_\_\_\_\_

Are you receiving any home health services? ☐ YES ☐ NO If YES, what services? \_\_\_\_\_

Previous **Physical Therapy / Occupational Therapy / Speech Therapy**, in the past 60 days? ☐ YES ☐ NO

**WHEN & HOW LONG:** \_\_\_\_\_

**WHERE?** ☐ Home Health ☐ Skilled Nursing Facility ☐ Hospital ☐ Other \_\_\_\_\_

Have you seen any other specialist? ☐ YES ☐ NO Who? \_\_\_\_\_



**SPEECH THERAPY INTAKE**

CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601

**EDUCATION/EMPLOYMENT**

Level of Education: ☐ High School ☐ College ☐ GED ☐ Other \_\_\_\_\_

☐ Working (full-time / part-time) outside the home ☐ Unemployed ☐ Disabled (reason): \_\_\_\_\_

☐ Working (full-time / part-time) inside the home ☐ Student ☐ Work restrictions: \_\_\_\_\_

☐ Retired ☐ Homemaker

Occupation: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse or partner's name: \_\_\_\_\_

Who lives in the home? \_\_\_\_\_

**Social History**

Do you currently smoke? ☐ YES ☐ NO

If no, previously? ☐ YES ☐ NO

Years smoked: \_\_\_\_\_ Packs/day: \_\_\_\_\_

Do you use other tobacco products (including vapes)? ☐ YES ☐ NO If yes, how often/day \_\_\_\_\_

Consume alcohol? ☐ YES ☐ NO If yes, drinks/week: \_\_\_\_\_

CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601

### MEDICAL HISTORY

**Have you ever been diagnosed with any of the following? Please list medications for each beside or under the diagnosis checked.**

- |                                                                                                                                |                                                |                                                              |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------|
| <input type="radio"/> ADD/ADHD                                                                                                 | <input type="radio"/> Esophageal Dilation      | <input type="radio"/> Myasthenia Gravis                      |
| <input type="radio"/> Asthma                                                                                                   | <input type="radio"/> Facial nerve palsy       | <input type="radio"/> Neck Surgery or Cervical Fusion        |
| <input type="radio"/> Alzheimer's/Dementia/memory loss                                                                         | <input type="radio"/> Fractures                | <input type="radio"/> Pacemaker                              |
| <input type="radio"/> Autism                                                                                                   | <input type="radio"/> GERD/Reflux              | <input type="radio"/> Parkinson's Disease/Huntington's       |
| <input type="radio"/> Bronchitis                                                                                               | <input type="radio"/> Guillain-Barre Syndrome  | <input type="radio"/> Pulmonary Embolism/Blood Clots/<br>DVT |
| <input type="radio"/> Cancer: if yes, what kind _____<br><input type="checkbox"/> Active OR <input type="checkbox"/> Remission | <input type="radio"/> Head Injury              | <input type="radio"/> Pneumonia                              |
| <input type="radio"/> Cerebral Palsy                                                                                           | <input type="radio"/> Hearing Loss             | <input type="radio"/> Seizures/Epilepsy                      |
| <input type="radio"/> Chemical Dependency                                                                                      | <input type="radio"/> Heart Problems: CHF/CAD  | <input type="radio"/> Sleeping Difficulties                  |
| <input type="radio"/> Cleft Palate                                                                                             | <input type="radio"/> Hepatitis                | <input type="radio"/> Stroke/CVA / TIAs                      |
| <input type="radio"/> COPD/ Emphysema                                                                                          | <input type="radio"/> High blood pressure      | <input type="radio"/> Lupus                                  |
| <input type="radio"/> Diabetes                                                                                                 | <input type="radio"/> Kidney Disease           | <input type="radio"/> Tuberculosis                           |
| <input type="radio"/> Degenerative Disc Disease                                                                                | <input type="radio"/> Chronic Laryngitis       | <input type="radio"/> Thyroid Issues                         |
| <input type="radio"/> Dysphagia/Swallowing Difficulties                                                                        | <input type="radio"/> Meningitis               | <input type="radio"/> Vision Problems                        |
| <input type="radio"/> Ear Infections                                                                                           | <input type="radio"/> MRSA / Cdiff / VRE / HIV | <input type="radio"/> Voice Changes                          |
|                                                                                                                                | <input type="radio"/> Multiple Sclerosis       | <input type="radio"/> Other _____                            |
|                                                                                                                                | <input type="radio"/> Muscular Dystrophy       |                                                              |

Surgical History: \_\_\_\_\_

Allergies (medication, food, etc.) \_\_\_\_\_

CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601

**SPEECH-LANGUAGE HISTORY**

| SYMPTOM                                                                  | NEVER | SOMETIMES | FREQUENTLY |
|--------------------------------------------------------------------------|-------|-----------|------------|
| Difficulty Swallowing                                                    |       |           |            |
| Difficulty expressing thoughts                                           |       |           |            |
| Difficulty being understood by others                                    |       |           |            |
| Difficulty understanding what others say to you                          |       |           |            |
| Orientation/Memory                                                       |       |           |            |
| Problem Solving                                                          |       |           |            |
| Focusing/Attention                                                       |       |           |            |
| Reading/Writing                                                          |       |           |            |
| Finding Words                                                            |       |           |            |
| Maintaining the topic of conversation                                    |       |           |            |
| Fluent Speech (stuttering)                                               |       |           |            |
| Following Directions                                                     |       |           |            |
| Oral motor weakness (difficulty coordinating tongue, cheeks, lips, etc.) |       |           |            |
| Voice difficulties                                                       |       |           |            |
| Any other difficulties, not listed above?<br>_____                       |       |           |            |

*CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601*

**What do you consider your greatest problem at this time?** (Circle all that apply below)

**Daily activities:** Dressing / Bathing / Cooking / Safety / Transfers / Communication / Eating or Swallowing

**Household:** Cleaning / Laundry / Lawn care / Shopping / Childcare / Computer / Telephone / Stairs / Finances

**Community Activities:** Shopping / Driving / Eating out / Stairs / Curbs / Appointments / Public Transportation

**Work:** What Activities? \_\_\_\_\_

**Recreation:** Sports/ Hobbies/ Sewing/ Gardening/ Games/ Travelling/ Woodworking/ Hunting

**Other:** \_\_\_\_\_

Do you receive supplemental feedings? ☐ YES ☐ NO

Type of supplemental feedings: \_\_\_\_\_ How much?: \_\_\_\_\_

Schedule for feedings: \_\_\_\_\_

Weight Gain/Loss: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_