Bon Secours Charity Health System - Speech Patient Health Questionnaire

Name: _____ Date of Birth: _____

Referring MD: _____ Next MD Appointment: _____

Would you like a copy of your reports sent to your Primary MD? ☐ Yes ☐ No
If yes: Primary MD Name: _____ Fax: _____

Current complaint or limitation: _____

Date of Injury/Onset: _____ ☐ Work Related ☐ Auto Accident ☐ School Injury

If your injury is the result of an accident, in what State did the accident occur? _____

If your injury is the result of an accident, is there currently any legal action being pursued? ☐ Yes ☐ No

Occupation: _____ Present work status: _____

Please list any surgeries and dates below: _____

_____

What is your goal for therapy? _____

Do you have any other aches and pains we should know about? ☐ Yes ☐ No

If Yes, please describe: _____

Past Medical History - Please check all that are applicable:

☐ High Blood Pressure	☐ Stroke	☐ Hepatitis	☐ Heart Attack
☐ HIV/AIDS	☐ Systemic Lupus	☐ Asthma	☐ Depression
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Pacemaker	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Tuberculosis	☐ Latex Allergy	☐ Currently Pregnant
☐ Osteoarthritis	☐ Angina	☐ Osteoporosis	☐ Anxiety
☐ CHF	☐ COPD	☐ Emphysema	☐ ALS
☐ GERD/LRPD	☐ Dementia/Alzheimer's Disease		☐ ASD (Autism)

Other: _____ ☐ Cancer - Location(s) and Date(s): _____

Please list any current medications with dosages you are presently taking (including prescription, over-the-counter, herbals, vitamins/minerals/dietary or nutritional supplements).

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Please see attached copy of medication list provided by the patient. ☐ I am not taking any medication.

Please list any X-rays, CT scans, or MRI tests performed and the results: _____

_____

Have you had speech therapy in the past for this same problem? ☐ Yes ☐ No

Have you had any speech therapy visits this year? ☐ Yes ☐ No
Number of therapy visits received this year: _____

ACCESS PHYSICAL THERAPY & WELLNESS
Preferred by Patients, Trusted by Physicians

Name: _____

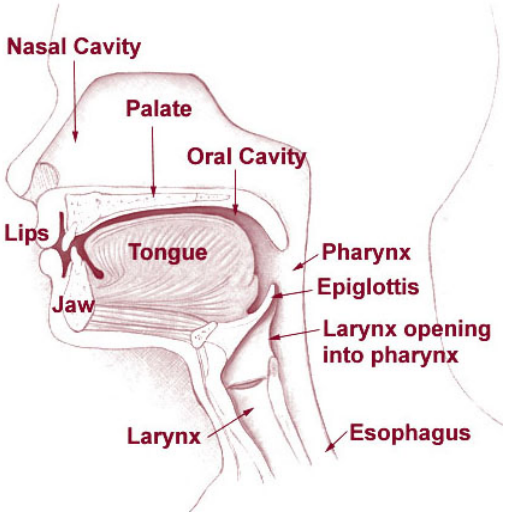
On a scale of 1 to 10, please indicate the intensity of your pain:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Please indicate if you cough during/after eating.

☐ Yes ☐ No

Please indicate if you get a lump in your throat (globus sensation) when eating/drinking. ☐ Yes ☐ No

On the diagram to the right, mark the location(s) of your pain.



What increases the pain? _____

What decreases the pain? _____

History of dysphagia? ☐ Yes ☐ No History of intubation? ☐ Yes ☐ No

Have you had a VFSS or FEES in the past 6 months? ☐ Yes ☐ No

Over the past 12 months, have you been able to verbally communicate? ☐ Yes ☐ No

Were you in a hospital or skilled nursing facility within the past 30 days? ☐ YES ☐ NO
If yes, reason for hospital stay _____
Dates of stay: From: _____ To: _____

Have you recently received any type of home care services? ☐ YES ☐ NO
What was the last date anyone came into your house for services? _____

Do you smoke or use smokeless tobacco products?
☐ No, I do not use tobacco products ☐ Yes, I smoke _____ packs per day
☐ Yes, I use smokeless tobacco products _____ times per day

Do you drink alcoholic beverages? ☐ Yes ☐ No
How many alcoholic drinks per day? _____ How many alcoholic drinks per week? _____

Please let us know how you heard about our facility:
☐ Sign out front ☐ Mailing ☐ Insurance Directory ☐ I was a previous patient
☐ A previous patient (please specify) _____ ☐ Newspaper ad
☐ Dr. _____ ☐ Phone book (please specify) _____
☐ Friend/Family (please specify) _____ ☐ Other: _____

Is there someone specific we may thank for referring you to us? ☐ Yes: _____ ☐ No

I am signing this form attesting to the best of my knowledge the information is accurate and reliable. I will notify the provider if any information changes.

Patient or Authorized Representative Signature: _____ Date: _____

Therapist Signature: _____ Date:_____