★★★ **Are you currently receiving ANY home health services? ❑ YES ❑ NO**

Name: _____ Today's Date: _____

Describe the problem that brings you to therapy:_____

Date problem began:_____
How did the problem begin and how has it been over time? _____

_____

Have you had treatment for this problem? If so, what kind?_____

Before this problem began, how well were you functioning? _____

Since then, has your problem: ❑ Worsened ❑ Improved ❑ Stayed same

What do you hope to achieve as a result of this treatment?_____

_____

Do you have pain? ❑ Yes ❑ No → If yes, please describe _____

_____

If yes, please rate your pain on the following pain scale: (Circle the number.)

0 (none) 1 2 3 4 5 6 7 8 9 10 (Severe)

If you have pain are you undergoing any treatment for it? ❑ No ❑ Yes If yes, please describe

_____

Are you currently working? ❑ Yes ❑ No If not, when was your last day of work? _____

What activities does your work require? (e.g., communication, vocal needs, telephone use, voice projection, cognitive functioning, etc.) _____

_____

Do you work in areas of high noise or pollution? ❑ Yes ❑ No If yes, please describe: _____

_____

Do you have any eating or swallowing difficulties? ❑ Yes ❑ No If yes, please describe: _____

_____

If yes, have you undergone any treatment for these difficulties? ❑ Yes ❑ No If yes, please describe:

_____

Have you had in the past any chronic difficulties, such as reflux, sinusitis, allergies, diabetes, pituitary dysfunction, etc.? ❑ Yes ❑ No If yes, please describe: _____

_____

Living arrangement: ❑ Alone ❑ With others _____

Describe what you do to keep physically fit: _____

Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year? ❑ YES ❑ NO If yes, please describe: _____

_____

→→→ OVER →→→

Do you have difficulty doing the following activities?

	YES	NO		YES	NO
Household Activities			Swallowing		
Work Activities			Money Management		
Understanding What Is Said To You			Talking		
Other: (please list)					

Are you pregnant now or is there a chance you could be? ❑ YES ❑ NO
Have you taken steroids for a prolonged period of time? ❑ YES ❑ NO

Have you had any tests recently? (X-Ray, CT Scan, MRI, EMG, ECG, etc.) _____

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: _____
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: _____
Preferred method of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Video ❑ Other: _____

In the space below, please tell us anything else you think your therapist will need to know: _____
_____

Staff Initials	Date	Time	ALLERGIES Do you have any allergies? ☐ No ☐ Yes, please list:	REACTION(S)

Staff Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses &/or significant conditions? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES Do you have any previous procedures or surgeries? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	CURRENT MEDICATIONS ☐ See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? ☐ No ☐ Yes, please list:

TIME/DATE	INITIALS	STAFF SIGNATURE	TIME/DATE	INITIALS	STAFF SIGNATURE

TIME: _____ DATE: _____ PATIENT SIGNATURE: _____

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SPEECH LANGUAGE PATHOLOGY OUTPATIENT INTAKE QUESTIONNAIRE

9.25.2017; Rehab

O.M.C. No. 1302

PLACE
PATIENT LABEL
HERE