SLP-chosen for you, from the Nicespeechlady.com library

SPEECH PATHOLOGY PATIENT: ______________________________

SPEECH PATHOLOGIST: __________________________________

SPECIAL INSTRUCTIONS: _________________________________

____ DATE: ________

ASSESSMENT AIDE: New Patient Questionnaire, Adult (page 1)

Instructions: please fill out the following information for the speech, language or swallowing assessment.

Person filling out this form: ___________________________________

Relationship to patient: _____________________________________

IDENTIFYING INFORMATION

Patient's name: ____

Patient's preferred name or nickname: ____

Date of birth: ____

Gender identity/preferred pronouns: ____

Relationship status: ____

Address: ____

Phone number: ____

Medical insurance or payment method/information: _____________________________________

Medical insurance details on card: ____

Secondary insurance (if any) ____

Secondary medical insurance details on card: ____

Other payments details: ____

Contact person/ primary caregiver: ____

Relationship of caregiver: ____

Caregiver contact information: __ ____

Special information to know regarding the patient: ______________________________________

GENERAL HEALTH INFORMATION:

Medical history/diagnoses: ____

____

____

____

Nice Speech Lady resources are intended for speech-language pathology professionals only – in order to augment treatment as indicated, or for general information-purposes for friends of the SLP profession. SLPs should access these resources and provide content up to the level of their experience, and liability of use of resources falls onto the responsibility of the SLP. See "Terms and Conditions." Please return back to Nice Speech Lady for additional copies and more materials for treatment home programs, resources and assessment tools. Copyright © 2022, The Nice Speech Lady, LLC.

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SPEECH PATHOLOGY PATIENT: ______________________________

SPEECH PATHOLOGIST: __________________________________

SPECIAL INSTRUCTIONS: ________________________________

____ DATE: ________

<u>ASSESSMENT AIDE: New Patient Questionnaire, Adult</u> (page 2)

Fluent languages: ___________________ ____

First language(s) of exposure: ____

Preferred language(s): ____

Vision status: ____

Hearing status: ____

Physical disabilities:____

Challenges with pain: ____

SPECIFICS REGARDING SPEECH, LANGUAGE & SWALLOWING:

Reason for the referral: ____

____

____

Biggest concern in this/these areas: ____

____

____

Previous level of functioning: ____

____How long ago: ______________________________

Details on history of speech therapy services: ____

____

____

____

Testing results/data available: ____

Other important information to share: ____

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SPEECH PATHOLOGY PATIENT: ______________________________

SPEECH PATHOLOGIST: ______________________________

SPECIAL INSTRUCTIONS: ______________________________

______________________________ DATE: ________

ASSESSMENT AIDE: New Patient Questionnaire, Adult (page 3)

Articulation concerns? Yes or No
If yes, details: ____
____

Voice concerns? Yes or No
If yes, details: ____
____

Swallowing concerns? Yes or No
If yes, details: ____
____

Memory concerns? Yes or No
If yes, details: ____
____

Following directions/understanding others' communication concerns (not related to hearing loss)? Yes or No
If yes, details: ____
____

Concerns regarding finding words? Yes or No
If yes, details: ____
____

Concerns on breath support for speech? Yes or No
If yes, details: ____
____

Stuttering concerns? Yes or No
If yes, details: ____
____

Social skills concerns? Yes or No
If yes, details: ____
____

Concerns regarding focus, impulsivity or safety/problem solving? Yes or No
If yes, details: ____
____

Concerns for using words effectively for communication to express thoughts and desires? Yes or No
If yes, details: ____
____

Concerns for needing augmentative/assistive communication to relay wants and needs? Yes or No
If yes, details: ____
____

Other concerns: ____
____

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SPEECH PATHOLOGY PATIENT: ______________________________

SPEECH PATHOLOGIST: ___________________________________

SPECIAL INSTRUCTIONS: _________________________________

_______________________________________ DATE: ________

ASSESSMENT AIDE: New Patient Questionnaire, Adult (page 4)

Greatest health challenges: ____

Greatest health strengths: ____

Is there a desire to implement a home program? Yes or No   If yes, is there family support? Yes or No

Preferences on a home program: ____

Areas of interest/likable topics: ____

____

____

Barriers to progress in therapy: ____

____

Potential solutions: ____

____

Preferences for the evaluation or treatment: ____

____

____

Requested questions to be addressed at the evaluation: ___________________________________

____

____

Other: ____

____

Thank you for taking the time to fill out this form. It will assist in the evaluation process.

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