The Physical Therapy Specialty Center

a division of **Primary Care Partners**
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"Our Head, Hearts and Hands Helping You to Better Health"

PATIENT HISTORY FORM – Speech - Adult **PLEASE PRINT**

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NAME: ____ Age: ________

Most Recent Doctors Appt: _____________ Have you received any HOME HEALTH services in the last 30 days? YES__ NO__

If yes, which agency? _____________________________ Discharged Date______________________

When did your symptoms begin? _____________________

Describe present problem ____

Is the problem the result of a car accident? Yes_____ No_____

Or workplace accident? Yes_____ No_____

Have you recently had surgery? Yes_____ No_____ if yes, for what? ____________________ Surgery Date: __________

Please check if you have had any of the following and if so, when:

Seizures______	High Fevers______	Migraine______	Allergies______
Pneumonia______	Aspiration Pneumonia______	Tonsillitis______	Meningitis______
Encephalitis______	Chronic Cough______	Rheumatic Fever______	Tuberculosis______
Sinusitis______	Chronic Colds______	Enlarged Glands______	Asthma/COPD______
CHF______	Frequent Falls______	GERD______	Vocal Cord Dysfunction_____
Stroke______	Traumatic Brain Injury______	Concussion______	Swallowing Difficulty______
Anxiety/Nervousness______	Cancer__________________	Circulatory Prob.________	Diabetes_________
Dizzy Spells_____________	Heart Disease/Trouble______	High Blood Pressure_____	HIV/HEP-C________
History of steroid usage____	Osteoarthritis___________	Pacemaker_______	Rheumatoid Arthritis_______
Pregnant_________	Vision Trouble/Hearing Loss _______	Other_________________	

Any accidents involving head or neck trauma or loss of consciousness? ____

Do you have metal implanted in your body? YES_____ NO_____ If yes, where? _________________________

List all Prescription MEDICATIONS you are currently taking____
____

Have you ever had Speech Therapy? Yes_____ No_____ If yes, indicate at what office and for what_____________________
Within this year have you been seen at another Speech Therapy clinic? Yes____ No____ How many visits_______

HOW DID YOU HEAR ABOUT US? Doctor_____ Friend _____ Other (please describe) ____________________

AUTHORIZATION FOR MEDICAL TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I consent to physical therapy treatment/provisions of modalities and procedures, as indicated by the therapist and/or physician; which includes Telehealth options. I have reviewed and agree with all office policies including Attendance and Patient Rights and Responsibilities.

PATIENTS SIGNATURE: ____ DATE: __________________

GUARDIAN'S SIGNATURE (if patient is under 18): ____