PROFESSIONAL SPEECH SERVICES
SPEECH THERAPY

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ADULT INTAKE PACKAGE - Past Medical History Questionnaire

Patient Name: _____ Date of Birth: _____

Reason for Therapy: _____

Date of Injury or Onset: _____

Have you ever received therapy for the condition mentioned above? _____

If so, when? _____ Treatment Received: _____

Previous Treatment: □ Successful □ Unsuccessful Could you be or are you pregnant: □ Yes □ No

Do you now or have you ever had any of the following:

Condition	***Yes***	***No***	***Condition***	***Yes***	***No***
Arthritis	□	□	Previous Surgeries	□	□
COPD	□	□	Hearing Loss	□	□
High Blood Pressure	□	□	Parkinsons	□	□
Heart Disease	□	□	Anxiety	□	□
Heart Attack	□	□	Substance Abuse	□	□
Pacemaker	□	□	Diabetes	□	□
CHF	□	□	Seizures/Epilepsy	□	□
Stroke	□	□	Cancer/Tumor	□	□
Asthma	□	□	Recent Weight Loss or Gain	□	□
Shortness of Breath	□	□	Current Infection(s)	□	□
Chronic Cough	□	□	Tuberculosis	□	□
Thyroid Problems	□	□	Hepatitis	□	□
Head Injury/Concussion	□	□	Other	□	□

If you have answered "yes" on any of the above, please explain and give approximate date(s):

_____

_____

Do you have any allergies: □ No □ Yes , list allergies:

_____

Are you presently taking any medications? □ No Yes, list medications and specify condition:

_____

How did you find out about our facility? _____

The information is correct to the best of my knowledge.

_____

Signature of Patient/Legal Guardian