# Medical History Form

Empowered Speech Pathology

**Empowered Speech Pathology, LLC, 1820 N Alston St. Suite C, Foley AL 36535**

**Patient Information:**

- Name: _____
- Date of Birth:_____ Social Security #: ___-___-_____
- Age: _____
- Gender: ☐ Male ☐ Female
- Address: _____
- Phone Number: _____
- Email: _____
- Emergency Contact Name: _____ Relationship: _____
- Emergency Contact Phone: _____

**Primary Care Physician:**

- Name: _____
- Phone Number: _____
- Address: _____

**Referral Information:**

- Referred By: ☐ Physician ☐ Therapist ☐ Self ☐ Other: _____
- Reason for Referral: _____

**Medical History:**

- Do you have any diagnosis or deficits in the following areas:

  ☐ Heart disease or Irregular heartbeat ☐ Pulmonary/breathing

  ☐ Swallowing/Dysphagia ☐ Neurological ☐ Vision ☐ Hearing ☐ Bowel Incontinence

☐ Bladder Incontinence ☐ History of Pneumonia-was it Aspiration Pneumonia?_____ Date: _____

☐ Falls- date of last fall?_____ ☐ Parkinson Disease ☐ Dementia ☐ Other

Please add specifics for issues checked above (specific diagnosis, onset date):

_____
_____
_____
_____

- Are you seeing a Physical or Occupational Therapist? ☐ Yes ☐ No
- Have you ever had surgery? ☐ Yes ☐ No
  If yes, please describe: _____
- Do you have any allergies? ☐ Yes ☐ No
  If yes, please list: _____
- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

- Have you had any hospitalizations? ☐ Yes ☐ No
  If yes, please describe/date: _____

**Speech and Language History:**

- Primary Language Spoken: _____
- Other Languages Spoken: _____
- Have you received speech therapy before? ☐ Yes ☐ No
  If yes, when and for what reason? _____
- Do you have difficulty with: ☐ Difficulty Speaking ☐ Understanding Language

  ☐ Voice Quality ☐ Stuttering/Fluency ☐ Swallowing ☐ Difficulty finding words

  ☐ Memory ☐ Other: _____

- When did you first notice these difficulties? _____
- Has the condition changed over time? ☐ Improved ☐ Worsened ☐ Stayed the Same
- Does anyone in your family have a history of speech, language, or hearing disorders? ☐ Yes ☐ No
  If yes, please describe: _____

**Additional Information:**

- Do you use any assistive devices (e.g., hearing aids, communication devices)? ☐ Yes ☐ No
  If yes, please specify: _____
- Do you have: ☐ Your own teeth ☐ Dentures/Partials ☐ No Teeth
- Any other concerns or relevant information? _____

**Signature:**
Patient/POA Signature: _____
Date: _____

**Office Use Only:** Clinician Notes:
_____
_____
_____

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Thank you for completing this form. Your responses will help us provide the best care possible!