NYSS
NEW YORK SPEECH SOLUTIONS

ADULT BACKGROUND HISTORY FORM

Name: ______________________ Date of Birth: ______________________
Address: ______________________
Home Phone: ______________________ Business Phone: ______________________
Cell Phone: ______________________ Email address: ______________________
Occupation: ______________________ Employer: ______________________
Person to contact in case of emergency:
Name: ______________________ Phone Number: ______________________
Relation to Insured: ______________________
Medicare #: ______________________
Secondary Insurance: ______________________ ID #: ______________________
Tertiary Insurance: ______________________ ID #: ______________________
Have you received outpatient speech therapy or physical therapy this year? ☐ Yes ☐ No
Are you enrolled with a Home Health Agency? ☐ Yes ☐ No
Referred by: ______________________
Reason for Evaluation: ______________________

MEDICAL HISTORY:

Have you had any major illnesses, diseases or injuries? ☐ Yes ☐ No
If yes, explain: ______________________

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Do you have a history of any of the following?

- ☐ respiratory problems
- ☐ endocrine/hormonal disorders
- ☐ neurological disorder
- ☐ No heart disease
- ☐ allergies
- ☐ ear infections
- ☐ psychological/psychiatric problems
- ☐ chronic sinusitis

Do you take any prescription drugs? ☐ Yes ☐ No
Please include name of medication, dosage and number of times/day medicine is taken. ______________________

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Do you take any nonprescription medications or dietary supplements on a regular basis? ☐ Yes ☐ No
Please include name of medication/supplement, dosage and number of times/day.

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Are you under the care of or have you had an evaluation by any of the following professionals?

☐ otolaryngologist (ENT)
☐ speech-language pathologist
☐ neurologist
☐ audiologist
☐ psychologist
☐ physical therapist
☐ psychiatrist
☐ occupational therapist
☐ endocrinologist
☐ respiratory therapist
☐ gastroenterologist
☐ allergist
☐ other ____________________

Name and address of professional(s) seen:

____

Why and when were you seen?____________________

Have you had any of the following?

☐ surgery on your larynx
☐ stroke
☐ heart surgery
☐ injury to the neck
☐ chest surgery
☐ chemical or inhalation exposure
☐ thyroid surgery
☐ tracheotomy

COMMUNICATION AND SWALLOWING:

Has your voice changed in the past year? ☐ Yes ☐ No

If so, please check all that apply: ☐ hoarse ☐ quieter ☐ whispery/breathy

☐ other____________________

What was the date of onset of your voice change? ____________________

Has your speech changed in the past year? ☐ Yes ☐ No

If you have difficulties with your speech, please check all that apply:

☐ slurring
☐ need to clear your throat more
☐ talking "through your nose"
☐ other ____________________

When was the date of onset of your speech change? ____________________

Do you have any problems with swallowing? ☐ Yes ☐ No

If so, when did the problem begin?____________________

Are you on a modified diet? (e.g. puree foods, thickened liquids) ☐ Yes ☐ No

Have you received a Modified Barium Swallow Test? ☐ Yes ☐ No

Have you received a Fiberoptic Endoscopic Evaluation of Swallowing? ☐ Yes ☐ No

If you were seen for either test, when and where were you seen? ____________________

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