JULIA HOBBS SPEECH PATHOLOGY, INC.

Patient's Name: _____ Date Of Birth: _____ Sex: _____

Home Address: _____ Home Phone#: _____

City/State: _____ Zip Code: _____

Age: _____ S.S.#: _____ Driver's License#: _____

Mobile Phone#: _____ Business Phone#: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Spouse's Name: _____ Age: _____ S.S.#: _____

Home Address: _____ Home Phone#: _____

Driver's License#: _____ Mobile Phone# : _____

Employer: _____ Occupation: _____

Employer's Address: _____ Business Phone#: _____

Referred By: _____ Physician: _____

Reason for Referral: _____

Speech Pathology services are provided for the patient with the understanding that payment for such services is solely the responsibility of the patient, parent, or guardian. Julia Hobbs Speech Pathology, Inc. will cooperate in assisting the patient to secure insurance reimbursement for speech therapy services. By doing so Julia Hobbs Speech Pathology, Inc. makes no expressed or implied representation that your insurance company will in fact recognize speech pathology services as an allowed benefit to you.
PAYMENT IS REQUIRED AT THE TIME OF SERVICE.
Failed appointments and late cancellations will be billed at our regular session rate. I have read and agreed to these policies.

DATE: _____ SIGNATURE: _____

FOR OFFICE USE ONLY:

DIAGNOSIS: _____

ADDITIONAL INFORMATION: _____

FINAL DISPOSITION: _____

Evaluation: _____ Therapy: _____ Therapist: _____

JULIA HOBBS SPEECH PATHOLOGY, INC.

Name: _____ Age: _____ Date: _____

COMPLAINT

Please state your main concern regarding your voice.

VOICE SYMPTOMS

When did you first notice a problem with your voice? _____

Please describe the course of the problem, the treatment you have had, where, and who treated you.

Please describe any feelings you have in your throat, such as tickle, pain, difficulty swallowing, strain, fatigue, etc.

Does your voice get better, worse, or stay the same throughout the day?

When is it better? _____

When is it worse? _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?

_____Allergies _____Neurological Problems _____Respiratory Problems _____Endocrine/Hormone Problems

HAVE YOU HAD ANY OF THE FOLLOWING?

_____Surgery on Larynx	When? _____	_____Thyroid Surgery	When? _____
_____Heart Surgery	When _____	_____Injury to the Neck	When? _____
_____Chest Surgery	When? _____	_____Chemical Exposure	When? _____
_____Stroke	When? _____	_____Inhalation Exposure	When? _____

DO YOU?

Smoke Tobacco or other Substances? _____How Much? _____

Drink Beer, Wine, other Alcoholic Substances? _____How Much? _____

DO YOU TAKE ANY MEDICATION REGULARLY?

What? *(Inlcuding Aspirin)* _____

EMPLOYMENT

Are You Currently Employed? _____Yes _____No

What Kind Of Work Do You Do? _____

_____

Is This A Vocally Demanding Job? _____Yes _____No

Please Describe: _____

_____

DO YOU EVER?

Talk Above Noise? _____

What Noise? _____ How Much?_____

Talk Loud, Scream, Yell? _____ How Much? _____

_____Sing _____Choir_____Solo_____With Musical Group_____

Please Add Any Other Information You Think May Be Pertinent: _____

_____

OTHER

_____

_____

_____