

## Austin Speech Labs Application

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone(s): Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  F  M

### Communication Information

Cause of the communication problem: \_\_\_\_\_  
\_\_\_\_\_

Date of onset of the communication problem: \_\_\_\_\_

Please describe your communication difficulties in each of the following areas:

Speaking:

\_\_\_\_\_  
\_\_\_\_\_

Understanding:

\_\_\_\_\_  
\_\_\_\_\_

Reading:

\_\_\_\_\_  
\_\_\_\_\_

Writing:

\_\_\_\_\_  
\_\_\_\_\_

Math:

\_\_\_\_\_  
\_\_\_\_\_

Other:

\_\_\_\_\_  
\_\_\_\_\_

Has your hearing been tested?  YES  NO  
Do you wear a hearing aid?  YES  NO  
Do you wear glasses?  YES  NO  
If so, for what reason?  Reading  Distance  Both

Did you have any communication problems before the stroke/accident/illness?

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Indicate any current or previous speech therapy services since your stroke/accident/illness: (dates, facility, clinicians, address, phone, email)

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What are your goals for communication?

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### Medical Information

List current medications and dosages:

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Do you take your medications independently?  YES  NO  
If not, please describe \_\_\_\_\_

Do you have any allergies?  YES  NO  
If yes, please describe \_\_\_\_\_

Are you on a special diet?  YES  NO  
If yes, please describe \_\_\_\_\_

Do you have trouble with walking?  YES  NO  
If yes, please describe \_\_\_\_\_

Do you use a wheelchair?  YES  NO  
 If so, do you use it independently?  YES  NO  
 Do you use a cane or a walker?  YES  NO  
 Do you have weakness or paralysis of your arm/hand?  YES  NO  
 If so, Right? Left?  YES  NO  
 Are you independent with transfers?  YES  NO  
 If no, please describe \_\_\_\_\_  
 Do you require assistance in the restroom?  YES  NO  
 Do you have special transportation requirements?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Are you currently receiving any other therapies? (ex: PT, OT, Vocational Rehab Services, Psychological Counseling services)  YES  NO  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Do you have any other long standing medical issues?  YES  NO  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Personal Information

Who do you live with (name and relationship):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Do you have any children?  YES  NO  
 Indicate names and ages:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Most recent occupation:  
 \_\_\_\_\_  
 \_\_\_\_\_

Were you employed at the time of your stroke/accident/illness?  YES  NO  
If so, where?

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Past Occupations?

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What was your highest level of education?

- 8<sup>th</sup> grade or less
- 9<sup>th</sup> – 11<sup>th</sup> grade
- High school graduate
- More than 12 years but not a college degree
- College graduate
- Advanced Degree

Is English your first language?  YES  NO

Did you ever speak another language fluently?  YES  NO  
If yes, which languages?

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What kind of leisure activities/hobbies did you enjoy before your stroke/accident/illness?

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Describe what you do in an average day

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Caregiver Information :

Name of primary caregiver: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home; work, cell) \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Physician Information:

Name of physician: \_\_\_\_\_