

Name: _____ Today's Date: _____

Describe the problem that brings you to therapy: _____

Date problem began: _____

How did the problem begin and how has it been over time? _____

Have you had treatment for this problem? If so, what kind? _____

Before this problem began, how well were you functioning? _____

Since then, has your problem: Worsened Improved Stayed same

What do you hope to achieve as a result of this treatment? _____

Do you have pain? Yes No → If yes, please describe _____

If yes, please rate your pain on the following pain scale: (Circle the number.)

0 1 2 3 4 5 6 7 8 9 10
(none) (Severe)

If you have pain are you undergoing any treatment for it? No Yes If yes, please describe _____

Are you currently working? Yes No If not, when was your last day of work? _____

What activities does your work require? (e.g., communication, vocal needs, telephone use, voice projection, cognitive functioning, etc.) _____

Do you work in areas of high noise or pollution? Yes No If yes, please describe: _____

Do you have any eating or swallowing difficulties? Yes No If yes, please describe: _____

If yes, have you undergone any treatment for these difficulties? Yes No If yes, please describe: _____

Have you had in the past any chronic difficulties, such as reflux, sinusitis, allergies, diabetes, pituitary dysfunction, etc.? Yes No If yes, please describe: _____

Living arrangement: Alone With others _____

09.0025



Olathe Medical Center

20333 West 151st Street
Olathe, Kansas 66061



**SPEECH LANGUAGE
PATHOLOGY OUTPATIENT
INTAKE QUESTIONNAIRE**

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Describe what you do to keep physically fit: _____

Do you have difficulty doing the following activities?	YES	NO
Dressing		
Hygiene (bathing, toileting, grooming)		
Household Activities		
Walking		
Skills with Dominant Arm		
Work Activities		
Sitting		
Understanding What Is Said To You		
Talking		
Swallowing		
Money Management		
Other: (please list)		

Are you currently receiving any home health services? YES NO

Are you pregnant now or is there a chance you could be? YES NO

Have you taken steroids for a prolonged period of time? YES NO

Have you had any tests recently? (X-Ray, CT Scan, MRI, EMG, ECG, etc) _____

In the space below, please tell us anything else you think your therapist will need to know: _____

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