SUMMIT THERAPY & HEALTH SERVICES

CENTERED ON EXCELLENCE

Please complete the following history to aid your therapist in your evaluation. This information will become part of your confidential records.

Please Circle The Condition Which You are Seeking Treatment For:

Speech Therapy Voice Therapy Swallowing Issues Cognitive/Thinking Skills

Name _____ Today's Date _____

Height _____ Weight_____ Age_____ Date of Birth_____

Reason for visit: _____

When did your condition start? _____ Occupation _____

Primary Doctor: _____ Referring Doctor: _____

How did you find out about Summit Therapy? _____

Have you had any imaging or testing for this condition? (X-ray, MRI, CAT scan, Blood Work) Describe:
_____

Are you currently taking any medications? If so, please list medication and the reason for taking: _____
_____
_____

Indicate significant past medical history and approximate date:
_____ Stroke _____ Heart Attack _____ TBI _____ Surgery _____ Other

Describe: _____
_____

How and when did the problem occur: _____
_____

Please comment on the condition which you indicated at the top of the document:

Voice: _____
_____
_____
_____

Swallowing: Coughing/Choking: Yes/no Recent Weight Loss: Yes/No
_____
_____
_____

Please Complete Page 2 on Back

Speech:

_____
_____
_____
_____

Thinking/Cognitive skills:

_____
_____
_____
_____

Describe any past treatment you have received for this condition:_____
_____
_____
_____
_____

What are your goals and expectations for therapy?_____
_____

_____ **Date:**_____

Signature