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