SPEECH PATHWAYS, P.C.

Neurological Speech-Language Questionnaire

Name of patient: _______________________________ **Date:** ________
Birth date: ____________ **Age:** ______ **Gender:** ______
Address: ____
Street City State Zip

Name of person completing form: ______________________________
Relation to patient: ____

Highest level of education completed (circle one):
High School College Graduate School Post-graduate school

Occupational History:
____
____
____
____

Hobbies/Interests:
____
____

Primary Language: ___________________________________
Secondary Language(s): _______________________________

Handedness (circle one): right left ambidextrous

Did/Do you suffer any of the following? (Please check)

___ CVA/Stroke
___ Head Trauma
___ Tumor
___ Multiple Sclerosis
___ Parkinson's Disease
___ Cerebral Palsy
___ Rheumatoid Arthritis
___ Other: ____
___ Spinal Cord Injury
___ Amyotrophic Lateral Sclerosis
___ Myasthenia Gravis
___ Muscular Dystrophy
___ Dystonia
___ Alzheimer's Disease
___ Pulmonary Disease

Nature and duration of present illness (Please provide copies of medical evaluations if possible):
____
____
____

If you suffered injury to the brain, where did the damage occur?
___ Right side ___ Left side ___ Brainstem
___ Other (please describe): ____

Do you have any weakness or paralysis of any part of the body? ____ If yes, where?
____
____

Hospitalizations (please state reason hospitalized, date, and length of stay):
____
____
____
____

Have you undergone any surgical procedures? ____ If yes, explain.
____
____

What medications are you currently taking?
____
____

Do you have difficulty with any of the following? (Please circle **all** that apply)

Speech	Word finding	Memory	Forming sentences
Writing	Depression	Reasoning	Following instructions
Drooling	Swallowing	Voice	Understanding what others say
Fluency	Attention	Confusion	Putting thoughts into words
Vision	Hearing	Reading	Reading comprehension
Tremor	Weakness	Anxiety	Being understood

Briefly describe the difficulties you are having in the circled areas:
____
____
____
____

What is your current primary communication modality? (Please check)
___ Speaking
___ Gesture/Sign
___ Writing/Typing
___ Communication device (specify): _________________________

Name: ________________________

Have you had speech-language therapy in the past? ____ If yes, when? Why?

____

____

Are you currently receiving occupational or physical therapy? Yes No

Do you **currently** live alone? Yes No
If you live with someone, do they work outside of the home? Yes No
On average, how many hours are you currently alone per day? ___________

Do you need assistance with any of the following?
___ Dressing ___ Bathing ___ Toileting ___ Eating ___ Using the telephone ___ Walking ___ Cooking ___ Driving ___ Other:
____

Do you have any sleeping problems? If yes, explain.

____

____

What is your greatest frustration related to communication?

____

____

____

____

If the clinician determines that speech-language therapy is indicated, what are your expectations? (e.g. What skills do you hope to improve and what activities do you hope to return to with therapy?)

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Please use the space below to provide additional information.

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