KVH
Kittitas Valley Healthcare
Speech Therapy
Your Home for Health

Speech Therapy Patient - Initial Health Questionnaire

Patient Name _____ DOB ___/___/___ Age _____ Today's Date ___/___/___

Referring Physician _____ Other/Primary Physician _____

1. For which problem(s) are we seeing you today? _____

_____

2. When did the symptoms start? _____

3. How do your symptoms vary over a 24-hour period?

Morning _____ Noon _____

Evening _____ Night _____

4. Are you currently being treated for other diagnosed medical problems? ☐ Yes ☐ No

If yes, please explain: _____

5. Have you had previous treatment for the same problem/symptoms? ☐ Yes ☐ No

If yes, please describe: _____

6. Have you had any diagnostic testing (e.g. x-rays, MRI, CT tests) for your current problem? ☐ Yes ☐ No

If yes, please describe: _____

7. What is your goal for your therapy treatment? _____

_____

8. Occupation: _____ 9. You live with: ☐ self ☐ spouse ☐ family ☐ other

10. Please list all current medications, including over-the-counter and supplements. Attach another sheet if necessary.

_____

_____

Please complete both sides of form.

KVH Speech Therapy | Initial Health Questionnaire, Cont.

11. Please list any allergies to foods, latex, adhesives, or medications: _____

_____

12. Have you been diagnosed with any of the following conditions?

	Yes	No
Recent infection	☐	☐
High Blood Pressure	☐	☐
Diabetes (with or without neuropathy)	☐	☐
Heart Problems	☐	☐
Stroke/TIA	☐	☐
Cancer	☐	☐
Bowel or Bladder Problems	☐	☐
Kidney Problems	☐	☐
Thyroid Problems	☐	☐
Breathing Difficulties	☐	☐
Seizures	☐	☐

	Yes	No
Frequent Falls	☐	☐
Osteoporosis	☐	☐
Arthritis (e.g. RA/rheumatoid, osteoarthritis)	☐	☐
Depression or Anxiety	☐	☐
Dizziness or Vertigo	☐	☐
Multiple Sclerosis	☐	☐
Hepatitis/Tuberculosis/MRSA (circle)	☐	☐
Headaches	☐	☐
Are you pregnant?	☐	☐
Other:	☐	☐

13. Is there anything else you'd like to tell us about your problem? _____

_____

_____

_____

THIS SECTION COMPLETED BY CLINIC STAFF

KVH Speech Therapist Reviewing Questionnaire *Date*