

★★★ Are you currently receiving ANY home health services?  YES  NO

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 (none)    1    2    3    4    5    6    7    8    9    10 (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 \_\_\_\_\_

Describe what you do to keep physically fit: \_\_\_\_\_

Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year?  YES  NO If yes, please describe: \_\_\_\_\_

→→→ OVER →→→

09.0025



**Olathe Medical Center**

20333 West 151<sup>st</sup> Street  
Olathe, Kansas 66061

**SPEECH LANGUAGE  
PATHOLOGY OUTPATIENT  
INTAKE QUESTIONNAIRE**

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**O.M.C. No. 1302**

PLACE  
PATIENT LABEL  
HERE

**Do you have difficulty doing the following activities?**

	YES	NO		YES	NO
Household Activities			Swallowing		
Work Activities			Money Management		
Understanding What Is Said To You			Talking		
Other: (please list)					

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.) \_\_\_\_\_

Languages you speak:  English  American Sign Language  Spanish  Other: \_\_\_\_\_

Preferred language for discussing healthcare:  English  American Sign Language  Spanish  Other: \_\_\_\_\_

Preferred method of communication:  Verbal  Sign Language  Written  Video  Other: \_\_\_\_\_

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

Staff Initials	Date	Time	<b>ALLERGIES</b> Do you have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	REACTION(S)

Staff Initials	Date	Time	<b>OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS</b> Do you have any other diagnoses &/or significant conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:

Staff Initials	Date	Time	<b>PREVIOUS PROCEDURES / SURGERIES</b> Do you have any previous procedures or surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:

Staff Initials	Date	Time	<b>CURRENT MEDICATIONS</b> <input type="checkbox"/> See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:

TIME/DATE	INITIALS	STAFF SIGNATURE	TIME/DATE	INITIALS	STAFF SIGNATURE

**TIME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **PATIENT SIGNATURE:** \_\_\_\_\_

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