Northwestern Medicine Palos Hospital
Rehabilitation Therapy Services

ADULT SPEECH OUTPATIENT QUESTIONNAIRE

Thank you for filling out this questionnaire. It will assist your doctor/therapist in planning safe and effective treatment.

Name: _____ **Date of Birth:** ___/___/_____ **Today's Date:** _____

What is your preferred language to discuss healthcare decisions? ☐ English ☐ Other: _____

Height: _____ **Weight:** _____ **Age:** _____ **Sex:** ☐ Male ☐ Female ☐ Right Handed ☐ Left Handed

Referring Physician: _____ **Next appointment date with Physician:** _____

How did you hear about our services?
☐ Physician ☐ Website ☐ Family/Friend ☐ Newspaper/Ad ☐ Fitness Center ☐ Social Media ☐ Employee (self or referral)
☐ Other Palos Health program/care ☐ Community Program (specify) _____ ☐ Other:_____

Have you received any Home Health Services in the past 30 days? ☐ Yes ☐ No If yes, explain: _____

How often do you have problems learning about your medical condition because of difficulty understanding health information?
☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never

Living Arrangements: ☐ Live Alone ☐ Live with family ☐ Other: _____
☐ Caregiver: ☐ 24 hours ☐ Part time

Occupation/Former Occupation: _____

Presently working? ☐ Yes ☐ No If no, last day worked?_____ # Days off Work: _____

What is the highest level of education you completed? _____

CURRENT CONDITION

Describe the current issue or recent surgery that brings you here today: _____

_____

Date of Surgery/Onset of issue: _____

Do you experience any of the following?: (Check all that Apply)

☐ Stuttering	☐ Difficulty swallowing pills/bread/meat	☐ Frequent throat clearing
☐ Increased phlegm in throat	☐ Nasal congestion when eating/drinking	☐ Frequent burping
☐ Increased throat/mouth dryness	☐ Difficulty clearing food from mouth	☐ Feeling of throat tightness
☐ Pain during the swallow	☐ Feeling of a lump in the throat when swallowing	☐ Increased cough when lying down
☐ Drooling during non-mealtimes	☐ Bad taste in the mouth (sour, acidic, metallic)	☐ Difficulty chewing
☐ Difficulty drinking with a straw/cup	☐ Unpredictable/variable loudness levels	☐ Throat soreness/burning
☐ Coughing	☐ Difficulty getting the swallow started	☐ Eyes watering during meals
☐ Ulcers or sores in mouth	☐ Dry mouth/throat	
☐ Difficulty expressing thoughts	☐ Difficulty being understood by others	☐ Orientation/memory issues
☐ Reading	☐ Difficulty understanding what others are saying	☐ Finding words
☐ Problem solving issues	☐ Focusing/maintaining attention	☐ Writing
☐ Difficulty completing daily tasks	☐ Maintaining topic of conversation	☐ Difficulty telling time
☐ Voice difficulties/changes	☐ Difficulty producing sounds (articulation)	☐ Complain others cannot hear you
☐ Oral motor weakness	☐ Decrease mouth/jaw opening	

Have you seen a Gastroenterologist or Otolaryngologist? ☐ No ☐ Yes

Have you ever had treatment before for these symptoms? ☐ No ☐ Yes Treatment: _____

Have you participated in an esophagram or videofluoroscopic study before? ☐ No ☐ Yes

Are your symptoms: ☐ Improving ☐ Staying the Same ☐ Getting Worse

Any recent weight loss/gain? ☐ No ☐ Yes _____# of lbs. over _____ weeks / months

Describe your appetite: ☐ Good ☐ Fair ☐ Poor

Do you have any dietary restrictions or avoid any food/drink items? ☐ Yes ☐ No (Please state any restrictions)

_____

Over →

Do you have any food allergies? ☐ No ☐ Yes _____

Length of mealtime: ☐ < 20 min ☐ 20-30 min ☐ > 30 min

Do you require assistance with your meals? ☐ No ☐ Yes (describe) _____

Do you wear dentures? ☐ No ☐ Yes - ☐ Upper ☐ Lower ☐ Partial ☐ Fits Well ☐ Poor fit

Describe the consistency of foods and liquids you are currently eating:

☐ Regular foods ☐ Cut up or Soft foods ☐ Finely Chopped ☐ Puree ☐ Thin Liquids
☐ Nectar Thick liquids ☐ Honey Thick liquids ☐ Feeding tube ☐ Other: _____

Please describe your voice: ☐ Normal ☐ Hoarse ☐ Breathy ☐ Weak ☐ No Voice

Do you take medication for reflux? ☐ No ☐ Yes

Has your hearing been tested recently? ☐ No ☐ Yes **Do you wear hearing aids?** ☐ No ☐ Yes

What is your goal as a result of treatment? _____

Do you currently use an assistive device? ☐ No ☐ Walker ☐ Cane ☐ Wheelchair ☐ Other _____

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _____ If yes, was there an injury involved? ☐ Yes ☐ No

Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you have worries about falling?** ☐ Yes ☐ No

Check any of the following medical problems you have ever had:

☐ Aphasia	☐ Arthritis Rheumatoid arthritis	☐ Anxiety	☐ Barrett's Esophagus
☐ Cancer	☐ Cellulitis	☐ Chronic Laryngitis	☐ Cleft Palate
☐ Depression	☐ Diabetes	☐ Dizziness/blackouts	☐ Dysarthria
☐ Dysphagia	☐ Esophageal Web	☐ Esophagitis	☐ Facial Nerve Palsy
☐ Fibromyalgia	☐ GI disorders (hernia, colitis, IBS, etc.)	☐ Headaches	☐ Head/Neck Cancer
☐ Hearing impairment	☐ Heart disease	☐ High blood pressure	☐ Kidney disease
☐ Lung disease or COPD	☐ Myasthenia Gravis	☐ Nerve damage	☐ Parkinson's Disease
☐ PEG tube placement	☐ Pneumonia	☐ Rheumatoid arthritis	☐ Schatzki's Ring
☐ Scleroderma	☐ Seizures	☐ Shingles	☐ Scleroderma
☐ Stroke/TIA	☐ TBI	☐ Thyroid problems	☐ Tuberculosis
☐ Vision problems	☐ Vocal fold abnormality	☐ Voice issues or changes	☐ Other _____

Do you have a Pacemaker? ☐ Yes ☐ No **Are you on blood thinners?** ☐ Yes ☐ No
Experienced radiation on head/neck? ☐ Yes ☐ No **Are you pregnant?** ☐ Yes ☐ No
History of tobacco use? ☐ Yes ☐ No **Do you drink alcohol?** ☐ Yes ☐ No

☐ **Allergies**: ☐ Iodine ☐ To Bees ☐ To tape ☐ Latex ☐ Gluten ☐ Other _____

☐ **Drug Allergies to:** _____

Other medical issues we should know about? _____

Please list any past Illness/Operation/Injury (with date) which required hospitalization. _____

_____

_____

In the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things: ☐ Not at all ☐ Several Days ☐ More than ½ the days ☐ Nearly every Day
Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several Days ☐ More than ½ the days ☐ Nearly every Day
Would you like help with how you're feeling? ☐ Yes – today ☐ Yes, but not today ☐ No

Do you take medications or drugs (including nonprescription drugs)? ☐ Yes ☐ No If yes, please list below or attach list.

NAME OF MEDICATION/DRUG	FOR WHAT?	NAME OF MEDICATION/DRUG	FOR WHAT?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient/Authorized Representative Signature _____ **Relationship to Patient** _____