Beebe Health Care Rehabilitation Services
Evaluation- Speech/ Language Pathology
Speech Language History Form - Adult

Patient Identification Label

SPEECH LANGUAGE HISTORY

Do you have difficulty?

	YES	NO
Swallowing		
Speaking/Expressing thoughts		
Being understood by others		
Understanding what others are saying to you		
With your memory		
Solving problems		
Focusing on tasks/ maintaining attention		
Reading/ Writing		
Finding or thinking of words(remembering names of objects/people)		
Maintaining topics of conversation		
With Stuttering		
Following directions		
Coordinating tongue, cheek or lip movement (Oral motor weakness)		
With your voice		

Are there any other difficulties besides what is listed above? _____

_____

_____

When did you first notice this problem? _____

_____

_____

Have you had Speech Therapy before?

Where? _____

When? _____

How long? _____

Patient Signature:_____ **Date:**_____ **Time:**_____

Therapist Signature:_____ **Date:**_____ **Time:**_____