Sage®
Communication Clinic

# Adult - New Patient Form

**Date:** _____

## Patients Information

**Name:** First_____MI_____ Last_____SS# _____

Sex: ▫ M ▫ F Age_____ Driver's License # _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

Employer:_____Occupation:_____ Business Phone #_____

E-Mail_____ Best Contact Method: ▫ Home ▫ Cell ▫ Work ▫ E-Mail ▫ Mail

**Spouse's Name:** First_____MI_____ Last_____SS# _____

Sex: ▫ M ▫ F Age_____ Driver's License # _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

Employer:_____Occupation:_____ Business Phone #_____

E-Mail_____ Best Contact Method: ▫ Home ▫ Cell ▫ Work ▫ E-Mail ▫ Mail

**Reason For Referral**_____

## Services Policy Agreement

Speech pathology services are provided for the patient with the understanding that payment for such services is solely the responsibility of patient, parent, or guardian. Sage Communication Clinic Inc. will cooperate in assisting the patient to secure insurance reimbursement for speech therapy services. By doing so Sage Communication Clinic makes no expressed or implied representation that your insurance company will in fact recognize speech pathology services as an allowed benefit to you.

**PAYMENT IS REQUIRED AT THE TIME OF SERVICE.**

**Failed appointment and late cancellations will be billed out our regular session rate. I have read and agree to these policies.**

Sign:_____Date:_____

## FOR OFFICE USE ONLY

Diagnosis:_____

Additional Information:_____

Final Disposition:_____

Evaluation:_____Therapy:_____Therapist:_____

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(Continued)

**Patient Name:** First_____Last_____ Age _____

## Complaint

Please explain the primary concern regarding your voice: _____

_____

_____

_____

_____

## Voice Symptoms

How long have you been concerned? _____

Please describe the course of the problem, the treatment you have had, where, and who treated you. _____

_____

_____

_____

_____

_____

Please describe any feelings you have in your throat, such as tickle, pain, difficulty swallowing, strain, fatigue, etc._____

_____

_____

_____

_____

_____

Does your voice get better, worse, or stay the same throughout the day?

When is it better?_____

_____

When is it worse?_____

_____

_____

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# Adult - New Patient Form

(Continued)

## Medical History

Do you have any of the following symptoms?

Allergies [ ] Neurological Problems [ ] Respiratory Problems [ ] Endocrine/Hormone Problems [ ]

Have you had any of the following?

Surgery on Larynx [ ] When?_____
Heart Surgery [ ] When?_____
Chest Surgery [ ] When?_____
Stroke [ ] When?_____

Thyroid Surgery [ ] When?_____
Injury to the Neck [ ] When?_____
Chemical Exposure [ ] When?_____
Inhalation Exposure. [ ] When?_____

Do you..... Smoke Tobacco or other Substances?_____How much?_____

Do you..... Drink Beer, Wine, other Alcoholic Substances?_____How much?_____

Does your child seem to be aware of the problem? ▫ Yes ▫ No

Do you..... take any medication regularly?_____What? (Inlcuding Aspirin)_____

_____

## Employment

Are you currently employed? ▫ Yes ▫ No

What kind of work do you do?_____

Is this a vocal demanding job? ▫ Yes ▫ No

Is "Yes" please describe:_____

_____

Do you ever .... Talk above noise? ▫ Yes ▫ No
What noise?_____How much?_____

Talk Loud/Scream/Yell?_____How much?_____

Sing [ ] Choir [ ] Solo [ ] With Musical Group [ ] _____

Please add any information you think may be pertinent:_____

_____

_____

Other:_____

_____