This questionnaire is a health inventory that gives us information about you and is a very important part of your treatment.

Questions? Contact Heather Holston, 480-365-9981, HeatherHolston@rztherapy.com.

Patient Information

Last Name: ____________________________ First Name: ____________________________ Birthdate:___________

Address:____

City:______________________________ State:_______ Zip Code:___________

Home Phone:_________________________ Cell Phone: _________________________ Preferred: Home Cell

Email:____ Referred by:_________________________________

Occupation:_______________________________________ Employer:_______________________________________

Marital Status: Married_____ (Spouse's name____________________) Single_____Widowed_____Divorced_____

Emergency Contact

Name:____

Home Phone:_________________________ Cell Phone: _________________________ Preferred: Home Cell

Please describe your concerns:
Do you have any eating or swallowing difficulties? If yes, describe:
What do you think may have caused the problem? Has the problem changed since it was first noticed?

Medical History

Date of last physical exam: _____/______/_____ How would you describe your health: Poor Fair Good Excellent

Physician(s): ____

Address:____ City:_____________________ State:_____ Zip: ________

Telephone: ________________________________ Fax: ________________________________

Are you under a doctor's current care? **Y N** **Why?**____

____

Please explain known medical problems/chronic illnesses: ____________________________________

____

____

____

Are you currently taking medication?

Medication	Dose	Reason?

Have you seen any other speech–language specialists? Who and when? What were their conclusions or suggestions?

Do you have any eating or swallowing difficulties? If yes, describe.______________________________

Describe any major accidents:

List any major surgeries, operations or hospitalizations (include dates):

Please provide additional information that may be helpful with your treatment:

Person completing form:____

Relationship to client:____

Signed:_________________________________Date:_______________

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