Whitefish Therapy & Sport Center

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Latest Referral Information _____ Motor Vehicle Accident _____

Latest Plan of Care _____ That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. Contact Ashley McGuire @ 406-862-9378.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

WHITEFISH THERAPY & SPORT CENTER

ADULT SPEECH THERAPY CASE HISTORY FORM

Patient Name: _____ **Age:** _____ **Date of Birth:** ____/____/____

Would you like to receive text or email reminders of appointments? ☐ **Yes** ☐ **No**

If yes, please provide cell phone provider and phone number or email address: _____

MEDICAL HISTORY: please check all that apply.

- ☐ Heart troubles
- ☐ Hypertension / High blood pressure
- ☐ Breathing issues or cough
- ☐ Stroke or TIA
- ☐ Concussion
- ☐ Reflux/GERD
- ☐ Dizziness
- ☐ Seizures
- ☐ Brain injury
- ☐ Allergies
- ☐ Cancer
- ☐ Sinus issues
- ☐ Thyroid issues
- ☐ Hearing loss
- ☐ Vision issues
- ☐ Anxiety/Depression
- ☐ Headaches
- ☐ Smoking
- ☐ Childhood stuttering or other speech concerns?
- ☐ Other

What is your primary speech, respiratory, swallowing or cognition (e.g., memory, thinking, organization) concern(s)?

_____

_____

Please list type of specialist/provider (e.g., physical therapist- PT, occupational therapist- OT, neurologist, ear/nose/throat -ENT, gastroenterologist-GI) that you've seen in past 6 months:

_____

_____

Symptoms	No	Yes	If yes, what if anything are you doing to compensate?
Swallowing difficulty?	☐	☐	
Unintended weight loss in past 3 months?	☐	☐	
Fatigue or persistent pain?	☐	☐	
Voice changes such as hoarseness or strained?	☐	☐	
Speech pronunciation difficulties?	☐	☐	
Trouble hearing?	☐	☐	
Forgetting to take medication or remembering doses/names?	☐	☐	
Difficulties reading written directions?	☐	☐	
Difficulties following written or spoken directions?	☐	☐	
Have trouble prioritizing daily tasks or getting things done on your to-do list?	☐	☐	
Difficulty with multitasking?	☐	☐	
Have trouble using technology such as phone, tablet, Fitbit/Apple Wach or computer?	☐	☐	
Have trouble remembering names of people you've just met?	☐	☐	
Need help with keeping track of appointments or important dates?	☐	☐	
Have trouble focusing or get easily distracted?	☐	☐	
Have trouble finding words?	☐	☐	
Have trouble remembering something someone just told you or something you just read?	☐	☐	

SOCIAL AND EDUCATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Check your work status: ☐ Full time ☐ Part time ☐ Out of work/disabled ☐ Retired

Highest level of education completed: ☐ Less than high school ☐ High school/GED
☐ College (general) ☐ College (technical) ☐ Masters ☐ Doctorial or Professional degree

Current or most recent job title: _____

Spouse, partner name and/or names of supportive friends/family: _____