

City Speech Centre

#375-2608 Granville St, Vancouver, BC, V6H 3V3
Telephone: 604-716-5241

Client Profile (Adult)

Client Name: _____ Date: _____

Date of Birth: ___/___/___ Age: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____

Work: _____

E-mail: _____

Present Occupation: _____

Highest Level of Education Completed: _____

School Presently Attending, if applicable: _____

Place of Birth: _____

Native Language: _____ Other Languages Spoken: _____

How did you find out about City Speech Centre? _____

Name of person filling out questionnaire: _____

Relationship to client, if other than client: _____

Services Requested: Speech-Language Evaluation
 Speech-Language Therapy
 Other _____

GENERAL INFORMATION

Describe the speech-language problem: _____

What do you think may have caused the problem? _____

Has the problem changed since it was first noticed (e.g. improved or worsened)? _____

Have you had a previous speech-language evaluation? Yes No

If yes, where and when? _____

If yes, what were the recommendations? _____

Have you had previous speech-language therapy? Yes No

If yes, where and when? _____

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, etc)?

Yes No

If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions. _____

Medical History

Do you have or have you had any eating or swallowing difficulties? Yes No

If yes, please describe:

Do you have or have you had any problems with your breathing? Yes No

If yes, please describe:

Do you have or have you had any problems with vocal quality? Yes No

If yes, please describe:

Please list any serious injuries, high fevers, seizures, hospitalizations, surgeries, neurological events or diseases, physical handicaps, or other medical information that you think may be relevant. Please give dates or approximate ages for each event.

Are you presently under the care of a specialist (e.g. neurologist, an ear- nose- and throat specialist (ENT), physiatrist (rehab M.D.), physical therapist, psychologist, or other? Yes No

If yes, please list each specialist's name, address, and type of specialty:

Please complete this chart regarding any medication that you are currently taking.

Medication	Dosage	Frequency of Administration	Reason for Meds

Please describe any problems with your teeth, tongue, mouth, ears, nose, or throat:

Are you right- handed or left- handed? _____

Describe any vision or hearing problems you may have: _____

FAMILY, SOCIAL AND EDUCATION INFORMATION

Do you have, or have you ever had, any school or learning problems? If so, please describe:

Do you have, or have you ever had, problems with memory or thinking? Yes No

If yes, please describe:

Is there anything else you would like us to know? _____
