Penn Medicine
Princeton Medical Center

Princeton Rehabilitation at Plainsboro

The Voice and Swallowing Clinic
Self-Assessment/Medical History

Date: ____________________

Section 1: Patient Identifiers & Risk Factors

Name: ______________________________ Age: ______ Date of Birth: ____________

Smoker: YES NO Pacemaker: YES NO Latex Allergy/Sensitivity: YES NO

Pregnant: YES NO

How did you hear about us? ____

Section 2: Medical History/Personal Factors (please circle any/all that apply)

□ Cancer (Type__________________ Currently receiving treatment: YES NO)

□ Diabetes	□ Kidney Disease	□ Liver Disease	□ Stroke/CVA
□ Osteoporosis	□ Heart Disease	□ Angina/Chest pain	□ Lyme's Disease
□ Osteoarthritis	□ Rheumatoid Arthritis	□ HIV	□ Asthma
□ Anemia	□ C-Diff	□ COPD/Emphysema	□ Hepatitis
□ Concussion	□ High Blood Pressure	□ Parkinson's Disease	□ Seizure/epilepsy
□ Tuberculosis	□ Hepatitis	□ Lung Disease	□ Blood clots
□ Circulation Disorder	□ Thyroid Disease	□ Fibromylagia	□ Incontinence
□ Falls (how many in past year?) __________		□ Multiple Sclerosis	

□ Other: ____

Fracture (please specify body part & date): ______________________________________

Metal Implants (please list): ____

Relevant Surgeries that may impact care (please list type & date): ________________________

____

Medications (please list): ____

____

Are you currently taking medication for the issue that brings you in today? YES NO

Do you currently take steroids/have you been on steroid in the past? YES NO

Are you currently working? YES NO Occupation (if yes): ______________________

Have you had speech therapy in the past? YES NO Did it help (if yes): YES NO

Section 3: Body Structure/Functions (circle any that occurred in the past week):

□ Fever/chills/sweats	□ Recent falls/poor balance	□ Numbness/tingling
□ Dizziness	□ Headaches	□ Change in bowel/bladder
□ Nausea/vomiting	□ Fatigue	□ Shortness of breath
□ Increased pain at night/sleepless	□ Unexpected weight loss/gain	□ Change in appetite
□ Malaise	□ Muscle weakness	□ Change in mental status
□ Change in vision	□ Recent infection	□ Pulsating pain
□ Palpitations	□ Chest pain	□ Difficulty swallowing
□ Leg swelling		

(continued on other side)

7 Plainsboro Road, Plainsboro, NJ 08536 • Tel 609.853.7830 • Fax 609. 853. 7831
www.princetonhcs.org

Penn Medicine
Princeton Medical Center

Princeton Rehabilitation at Plainsboro

Are you experiencing any other symptoms that are not normal to you? ______________________________
____

Section 4: Current Symptoms

Date (approximate) of your injury, surgery, or onset of symptoms: __________________
How did your symptoms occur? □ Neurological Event □ Surgery □ Gradual onset □ Unknown
□ Other ____
Have you had an X-Ray, MRI or any other diagnostic imaging done for this condition? YES NO
(If yes, please explain):
____

With 0 being none & 10 being the worst pain imaginable (emergency room pain) please rate your pain: _______

Have you received or are you currently receiving treatment for this condition? YES NO
(If yes please explain): ____

What makes your symptoms better?____
What makes your symptoms worse? ____

Section 5: Social Screening

Over the past 2 weeks, have you felt "down" or depressed?	YES	NO
Over the past 2 weeks, have you felt little interest/pleasure in doing things?	YES	NO
Do you feel your quality of life is impacted because of this condition?	YES	NO

Section 6: Activity Limitation and/or Participation Restriction

Please list up to three activities with which you have difficulty OR cannot perform due to this condition:

1. ____
2. ____
3. ____

What are your goals for speech therapy? ____
____

I have completed this form to the best of my ability & the information is correct.

____________________________________ ____________________
Patient's signature Date

I have reviewed this information with the patient

___________________________ ____________________
Speech-Language Pathologist's signature Date