AUSTIN SPEECH LABS
stroke recovery one word at a time

Client Application

Name of person completing this application: _____

Client Information

Name: _____
Address: _____
City: _____
State: _____
Zip Code: _____
County: _____
Phone Number – Cell:_____
Phone Number – Home: _____
Email: _____
Date of Birth: _____
Sex: Male / Female
How did you hear about Austin Speech Labs?
_____

Communication Information

Cause of the communication problem: _____
Date of onset of the communication problem (MM/DD/YYYY): _____
Please describe your communication difficulties in each of the following areas:
Speaking:
_____
_____
_____
Understanding:
_____
_____
_____
Reading:
_____
_____
_____
Writing:
_____
_____
_____
Math:
_____
_____
_____
Other:
_____

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Phone: 512-992-0575 Fax: 512-900-7977 www.austinspeechlabs.org

_____
_____

Have you had your hearing tested? _____
Do you wear a hearing aid? _____
Do you wear glasses? _____
If yes, do you wear glasses for reading, distance, or both? _____
Did you have any communication problems before the stroke/accident/illness? Please describe

_____
_____
_____

Indicate any current or previous speech therapy services since your stroke/accident/ illness:
(Dates, facility, clinicians, address, phone, email)

_____
_____
_____

What are your goals for communication?

_____
_____
_____

Medical Information
List current medications and dosages:

_____
_____
_____

Do you take your medications independently? _____
If no, please describe:

_____
_____
_____

Do you have any allergies? _____
If yes, please describe:

_____
_____
_____

Are you on a special diet? _____
If yes, please describe:

_____
_____
_____

Do you have trouble with walking? _____
If yes, please describe:

_____

_____
_____
Do you use a wheelchair? _____
If yes, do you use the wheelchair independently? _____
Do you use a cane or a walker? _____
Do you have weakness or paralysis of your arm/hand? _____
If yes, right or left arm/hand? _____
Are you independent with transfers? _____
If no, please describe:
_____
_____
Do you require assistance in the restroom? _____
Do you have special transportation requirements? _____
_____
Are you currently receiving any other therapies? Check all that apply
__ Physical Therapy
__ Occupational Therapy
__ Vocational Rehab Services
__ Psychological Counseling Services
__ Other
If you selected other, please describe:
_____
_____
_____
Do you have any other long-standing medical issues?
_____
_____

Physician Information
Name of physician(s):
_____
_____
_____

Personal Information
Who do you live with (name and relationship)? _____
Do you have Children? _____
If yes, please list their names and ages
_____
_____
_____
Most recent occupation: _____
Were you employed at the time of your stroke? _____
If yes, where? _____
Past occupations? _____
What was your highest level of education? _____
Is English your first language? _____

Did you ever speak another language fluently? _____
If yes, which language(s)? _____
What leisure activities/hobbies did you enjoy before your stroke?

_____
_____
_____

Describe what you do in an average day:

_____
_____
_____
_____

Caregiver Information

Name of primary caregiver: _____
Relationship to client: _____
Address: _____
City: _____
State: _____
Zip code: _____
Phone Number – Cell: _____
Phone Number – Home: _____
Emergency Contact: _____
How many people are living in your house? _____
What is your estimated household income per year? _____
What time would you prefer to have therapy? Morning (9-12) Afternoon (1-4)

Due to a NEW building parking policy – Please provide car make, model and year (for ALL cars in household): If you are not driving please write "NA"

_____
_____
_____