Stony Brook Medicine

# Speech Pathology Update History form

Name_____ Date of birth: _____

Address _____

Phone: home# _____ Cell #_____

Name Parent/Guardian/Spouse_____

Insurance _____Policy #_____

For explanation of results/treatment plan to you and your family attending the appointments, are there any cultural practices or barriers to learning that the clinician needs to know ? ☐NO ☐YES,(explain)_____

_____

Preferred language_____ Need interpreter: ☐YES ☐NO

Any other information that you feel would be important for us to know?

_____

_____

Do you experience any temporary or chronic pain? ☐NO ☐YES, (explain)_____

_____

Speech Pathologist's Notes:_____

_____

_____

_____

_____

If yes response to pain : ☐ provided pain brochure

Rating of pain: 1 2 3 4 5 6 7 8 9 10

_____ _____

Speech Pathologist's signature Date/Time