Prohab
Therapy Specialists

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PATIENT HISTORY/INTAKE FORM

Today's Date: _____

Name: _____Date of Birth_____

Birth/Medical History: Please describe any health/medical problems/concerns (serious accidents, substance abuse, illness, etc.):

_____
_____
_____
_____

Were you born with a hearing loss or acquire it? Please describe:

_____
_____

Ear Infections (how many) _____

Family history of hearing loss? When was family member diagnosed?

_____

Please describe hearing technology wear schedule (e.g. length of time hearing aids/cochlear implants are worn) and name of devices:

_____

Audiologist (name and contact information): _____

Primary Care Physician (name and contact information):_____

List all medications you are currently taking:

_____

Any negative reactions to these medications? Describe_____

Describe your educational/work history (e.g. where you went to school, college)?

Are there any other speech, language, learning, or hearing problems in your family? If yes, please describe.

Have you seen any other specialists (physicians, ENT, neurologist, Physical Therapist, Occupational Therapist, etc.)? If yes, indicate type of specialist, dates seen and the professional's conclusions or recommendations.

Provide any additional information or concerns that might be helpful in the evaluation and development of your treatment plan.

On occasion, photographs or video may be taken of a therapy session for monitoring progress, presentations, and/or community events. I give my permission to be photographed and/or videoed, with the understanding I will be notified prior to either.

_____

Patient Signature

Date: _____