ADULT

speechcare
Speech pathologists who care

Name:	Date of Birth:	Age:
Account to be made out to:		
Mobile phone:	Home phone:	Work phone:
Email address:		
Postal address: State: Post code:		
Do you have private health insurance? ☐ Yes ☐ No	Name of fund:	
How did you hear about us? ☐Google ☐Website ☐ Yellow pages ☐Walk in ☐Family/ Friends ☐Other: ☐GP/ Specialist (please specify referral details):		

What was the main reason for this referral? (please tick)

☐ Lisp ☐ Stutter ☐ Accent Reduction ☐ Comprehension of language

☐ Voice ☐ Medical ☐ Other (please specify):

Do you speak a language other than English at home? If yes please specify: ☐ Yes ☐ No

Medical History - *Please provide copies of relevant medical reports.*

Are there any diagnosed illnesses/ disorders? If yes please provide details ☐ Yes ☐ No

Have you been recently hospitalized? If yes please provide details ☐ Yes ☐ No

Have you had any recent operations? If yes please provide details ☐ Yes ☐ No

Is there a history in your family of:

☐ Heart disease ☐ Blood pressure ☐ Asthma ☐ Stroke

☐ Diabetes ☐ Hearing loss ☐Allergies (eg hay fever)

☐ Cognitive changes (e.g. Dementia) ☐ Neurological conditions (e.g. Parkinson's)

☐ Digestive conditions (e.g. reflux, ulcers) ☐ Other:

Please provide details:

Please list current medication and the reason:

Any natural/ complementary therapies:

Previous Intervention

Has your child ever been assessed by a Speech Pathologist or received speech therapy? ☐ Yes ☐ No

If yes please provide details:

Has your child been assessed by a medical or other allied health professional (Psychologist, Physio, OT)? ☐ Yes ☐ No

If yes please provide details:

Consent to share information with other professionals

At times, it is important that information is shared with other relevant professionals such as a GP, a referring specialist or allied health professional. Your consent is required for information to be shared.

I, _____ (name), consent to Speechcare providing relevant information to other professionals as required.

Signature: Date:

Acknowledgement

Non-Attendance: A minimum of **24 hours notice** is required for appointment changes or cancellations. **Appointments cancelled or changed with less than 24 hours notice will be charged a $40 fee.** Message bank is available outside office hours for your convenience. **Please do not cancel via SMS**, cancellations must be via phone call as SMS messages are not always reliable.

Signature: Date:

Thank you for taking the time to complete this form.