HPI Speech

History of Present Illness

Why are you here today? (Select one)
- ◯ language
- ◯ speech
- ◯ swallowing/feeding
- ◯ cognition/learning
- ◯ voice

How would you describe your current problem: ______

On what date did this occur? ______

How would you describe the onset of this problem? ◯ sudden ◯ gradual

Have you been hospitalized for your present illness? Yes No

if yes, please list the date of admission and the length of stay. ______

Have you seen a specialized physician for this illness? Yes No

If yes, select all applicable:
- ☐ Neuropsychologist
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Pulmonologist
- ☐ ENT (Ear, Nose, and Throat)
- ☐ GI (Gastroenterologist)
- ☐ Neurologist

Do you have a neurological disease/injury? Yes No

If yes, select one of the following:
- ◯ a stroke
- ◯ Parkinson's disease
- ◯ a brain injury
- ◯ ALS
- ◯ Primary Progressive Aphasia
- ◯ dementia
- ◯ cancer
- ◯ other

How would you describe your current problem?
- ◯ sudden
- ◯ chronic
- ◯ progressive
- ◯ other

Do you have pain or headaches? Yes No

Which side? (Select all that apply) ☐ left ☐ right

Where is this pain located? (Select all that apply)
- ☐ neck
- ☐ upper back
- ☐ face
- ☐ head
- ☐ other

What makes this pain worse? (Select all that apply)
- ☐ talking
- ☐ walking
- ☐ cough/sneeze/holding breath
- ☐ driving
- ☐ thinking
- ☐ reading
- ☐ lights
- ☐ noise
- ☐ listening

What makes this pain better? (Select all that apply)

- [ ] nothing
- [ ] rest
- [ ] pain medication
- [ ] ice
- [ ] heat
- [ ] bracing
- [ ] cane/walker
- [ ] immoblization
- [ ] elevation
- [ ] cortisone injections
- [ ] sitting
- [ ] standing
- [ ] walking
- [ ] overhead reaching

How would you describe this pain? (Select all that apply)

- [ ] dull
- [ ] sharp
- [ ] aching
- [ ] throbbing
- [ ] shooting
- [ ] constant
- [ ] intermittent

Do you have other impairments in memory, language, speech, swallowing, and/or voice? Yes No

Swallowing:

- [ ] swallowing liquids
- [ ] swallowing solid foods
- [ ] taking pills
- [ ] eating textured food
- [ ] eating variety of foods
- [ ] coughing
- [ ] choking
- [ ] drooling

Cognition:

- [ ] alertness
- [ ] attention/concentration
- [ ] executive functioning (planning, organization, time maintenance)
- [ ] temporal disorientation (confusion with dates and time)
- [ ] spatial disorientation (getting lost)
- [ ] personal disorientation (recognizing self and others)
- [ ] short term memory
- [ ] long term memory
- [ ] sequencing activities
- [ ] numerical reasoning (addition, subtraction, etc...)
- [ ] self awareness
- [ ] problem solving
- [ ] other

Language

- [ ] word finding
- [ ] expressing needs/wants
- [ ] sentence structure
- [ ] organization of thoughts and ideas
- [ ] auditory comprehension (understanding what you hear)
- [ ] reading comprehension
- [ ] writing
- [ ] paraphasias (sound and word substitution errors)
- [ ] no language/limited language expression
- [ ] other

Speech: ☐ slurred speech ☐ strained speech ☐ quiet speech ☐ discoordinated speech ☐ effortful speech ☐ other

Voice: ☐ breathy voice ☐ quiet voice ☐ hoarseness ☐ strained/strangled voice ☐ pitch breaks ☐ other

What hand is dominant? (Select one) ○ right handed ○ left handed ○ ambidextrous (both)

Have you had any diagnostic tests done? (Select all that apply) **Yes** **No**

☐ Xray
☐ CT
☐ MRI
☐ MBS

Do you currently have numbness and tingling? Yes No

If yes, where? (Select all that apply)

☐ right upper extremity ☐ left upper extremity
☐ right lower extremity ☐ left lower extremity
☐ left face ☐ right face
☐ oral cavity

Additional Comments:

Have you had any other forms of therapy previously? **Yes** **No**

If yes, select the location where the therapy occurred. (Select all that apply.)

☐ inpatient rehabilitation center ☐ subacute rehabilitation center
☐ home rehabilitation ☐ outpatient rehabilitation
☐ skilled nursing facility

If yes, select the type of therapy received. (Select all that apply.)

☐ occupational therapy ☐ physical therapy
☐ speech therapy

If yes, when did you receive these therapies and for how long?

Do you use any assistive devices for speech, language, cognition, or swallowing? **Yes** **No**

If yes, select all that apply.

☐ PEG tube for feeding ☐ communication book
☐ assistive communication device ☐ calendar and/or agenda book
☐ smartphone with reminders ☐ alarms
☐ hearing aids ☐ eyeglasses

Are you able to safely swallow a regular diet and thin liquids without coughing? Yes No

Do you have any diet restrictions? Yes No

If yes, select all that apply.

- ☐ diabetic diet
- ☐ cardiac diet
- ☐ nectar thick liquid
- ☐ honey think liquid
- ☐ puree solid food
- ☐ mechanical soft solid food
- ☐ food cut into small pieces
- ☐ no added salt
- ☐ require feding assistance

Has your doctor given you precautions or restricted you from any of the following?

- ☐ driving
- ☐ swallowing/diet
- ☐ being unsupervised
- ☐ activity level
- ☐ returning to work
- ☐ other

Home Environment

How would you rate your health? ○ excellent ○ good ○ fair ○ poor

How many falls have you had in the past 6 months? ○ 0 ○ 1 to 2 ○ >3

Is English your primary language? Yes No

List any other languages you speak fluently: __________

What is the highest degree or level of education you have completed?

- ○ some high school no diploma
- ○ high school/GED
- ○ some college credit, no degree
- ○ Associate degree
- ○ Bachelor's degree
- ○ Master's degree
- ○ Professional degree
- ○ Doctorate degree

What is your employment status? ○ employed ○ unemployed ○ retired

What do you do for a living? __________

What are your leisure activities/hobbies? __________

If currently on leave, do you plan to return to work? Yes No

If yes, select one that applies.

- ○ return to previous job without accommodations
- ○ return to previous job with accommodations
- ○ find new employment to fit current level of functioning

Do you live alone? ○ alone ○ with someone

Do you require assistance at home? Yes No

Does anyone come to your home to provide health care services? Yes No

If yes, select all that apply. ☐ nursing ☐ social work ☐ caregiver ☐ respiratory ☐ other

If yes, please list the agency name and phone number:

What type of home environment do you live in?

☐ house ☐ apartment
☐ condominium ☐ mobile home
☐ assisted living ☐ retirement center
☐ nursing home ☐ other

Goals/Followup

What are your goals for therapy?

When are you scheduled to return to the doctor for follow-up?

○ as needed ○ within 1 month
○ after completion of therapy

Additional Comments:

Prior Level of Function

Were you independent prior to this incident? Yes No

If you were NOT independent prior to this incident, please check the activities you needed help with. (Select all that aply.)

☐ bathing ☐ dressing
☐ grooming ☐ driving
☐ finance management ☐ cooking
☐ yardwork ☐ communicating
☐ self feeding ☐ toileting
☐ school work ☐ housework
☐ medication management ☐ other

What life roles were impacted due to this incident? (Select all that apply.)

☐ caregiver ☐ parent ☐ grandparent
☐ homemaker ☐ employee ☐ employer
☐ friend ☐ companion ☐ spouse
☐ volunteer ☐ student