

SPEECH THERAPY EVALUATION

PATIENT INFORMATION

PATIENT NAME		AGENCY#	REFERRAL SOURCE/DATE	
STREET ADDRESS		SEX	DATE OF BIRTH	TELEPHONE
CITY, STATE, ZIP CODE		HEALTH INSURANCE NUMBER		
PHYSICIAN		OFFICE PHONE NUMBER		
NAME OF RESPONSIBLE PARTY		EMERGENCY NOTIFICATION NUMBER		
NAME OF HOSPITAL/SNF		DATES OF STAY	HOME	OFFICE
DIAGNOSIS PRIMARY		DATE OF ONSET	PRIOR SPEECH THERAPY Rx/DATES OF SERVICE	
SECONDARY		FREQUENCY/DURATION OF VISIT		
		REHABILITATION POTENTIAL		

HISTORY

BRIEF HISTORY OF CONDITION _____

CLINICAL FINDINGS

I. RECEPTIVE LANGUAGE:

A. IDENTIFICATION OF COMMON OBJECTS

B. FOLLOW COMMANDS 1 STEP 2 STEP 3 STEP

II. EXPRESSIVE LANGUAGE:

A. READING (ORAL AND COMPREHENSION)

B. WRITING SKILLS (DICTATION AND COPIED)

C. VERBAL RESPONSE (TO QUESTIONS AND STATEMENTS)
