Aphasia History Form

Name of Applicant:		
Street Address:		
City	State	Zip code
Home ph#		Cell phone #
Email:		
DOB:	Age:	Gender:
Have you applied to this program before?		
Preferred dates of attendance:		
Name of person completing this form:		
Email:		
Caregiver Information:		
Name:		
Relationship to Applicant:		
Phone:	Email:	
Marital Status:		Spouse's name:
Spouse's occupation:		
Ph#		
Email:		

Language Skills: please describe what tasks you have trouble doing:
1.
2.
3.
Please check one of the following boxes:
☐ I cannot speak ☐ I speak in single words ☐ I speak in phrases ☐ I speak in sentences
☐ I can formulate questions ☐ I can carry on a conversation
☐ I can comprehend words
Please check one of the following boxes:
☐ I cannot read ☐ I read single words
☐ I can read the newspaper ☐ I can read books

Please check one of the following boxes:
☐ I cannot write ☐ I can write my name ☐ I can write single words ☐ I can write sentences
☐ I can formulate a letter ☐ I can email people
History:
Nature of Illness/accident: Date:
Were you unconscious? If so, for how long? Were you paralyzed? Where? Were you right or left handed before the present problem?
Previous Facility or Clinic you were treated at:
Name of Facility:
Type of Facility (hospital, outpt, home health):
Personal Information:
Do you use the bathroom independently?
Do you wear glasses?
Can you walk independently?
Do you use a wheelchair?
Are you able to follow a schedule without direct supervision?
Can you take your medication independently?
Do you wear a hearing aid?
Please list 2 previous jobs:
Please describe 2 hobbies:
Please describe 2 activities you enjoy doing:
Please describe 2 books you would like to read:
Previous Speech Therapy Clinic:
Professional's Name:
Address:
Phone #:
Dates attended:

Educational History: Please list your high school, college and graduate education.
Medical History: Please have your physician, speech-language pathologist, and hospital include a copy of your medical records and include it with this application.