Cognitive Memory Traumatic Brain Institute

Name:		**Date:**
Occupation:		**Full-time or Part-time**
Referring MD:		
ENT:	**Neurologist:**	
Primary Physician:	**Gastroenterologist:**	**Pulmonologist:**
Medical History:		
Surgery History:		
Hospitalizations:		
Describe your cognitive, speech, or memory problem in one sentence or less: _____		
When did it first occur?		
What is your goal of speech therapy? **Have you had speech therapy before?** **When?** **Where?**		

Previous Speech Therapy Clinic:
Professional's Name:
Address:
Phone #:
Dates attended:
Educational History: Please list your education and college and graduate education.
Medical History: Please have your physician and speech pathologist and hospital include a copy of your medical records and include it with this application.

Cognition/Memory:

1. What caused your memory loss?_____
2. What tasks are hard for you to do now?_____

Never=0 points, Almost Never=1 point, Sometimes=2 points, Always=3 points, Always=4 points

The Source for Executive Functions (Enter a "0,1,2,3, or 4")	Never 0	Almost Never 1	Sometimes 2	Almost Always 3	Always 4
1. I find it hard to determine my 2-3 priority tasks for the day.					
2. I find it hard to schedule my 2-3 important tasks for the day.					
3. I find it hard to know the steps involved in completing my 2-3 tasks.					
4. I can't accomplish my 2-3 tasks daily.					
5. I'm not efficient in completing tasks.					
6. I don't complete tasks by their deadline.					
7. I find it hard to get started on tasks and don't procrastinate.					
8. I find it hard to stop working on a task when it is time to do something else.					
9. I am easily distracted from the activity at hand.					
10. I can't work on my difficult tasks when my energy is at its peak.					
11. Tasks typically take more time than I expect.					
12. I am not able to modify my schedule when things don't go as planned.					
13. I delay difficult tasks.					
14. I forget appointments I've made.					
15. I am late for engagements.					
16. I often don't return calls when I say I will.					
17. I can't complete projects in an organized fashion.					
18. I can't see different ways to complete a task.					
19. I don't feel like I have enough mental energy during the day.					
20. My daily activities don't reflect and support my overall goal.					

(Staff will calculate:) Score _____ / 80 =_____ % handicap

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 read newspapers ____ I 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: