Center for Aphasia Research & Treatment
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I A a aT a P a A ca

Na a c a :

Add :

C : S a : Z :

P ( ): H C W

E a :

Da b : S : ☐F ☐M

Da : Ca A a a:

Communication Information

For the following, check all that apply and provide additional information as appropriate:

Speech

☐U c
☐P d
☐Sa d
☐U ab a d
☐Add a a :

Understanding

☐F a c a
☐U d a d c a
☐U d a d a d d c
☐D a d a d c a
☐Add a a :

Reading

☐R ad b
☐R ad a a d a a a c
☐R ad c (. . a ad)
☐R ad d
☐D ad
☐Add a a :

Writing

☐W c
☐W d
☐W a a d add
☐D
☐Add a a :

Ma :

O :

Has your hearing been tested? ☐Y ☐N I , ?

Do you wear a hearing aid? ☐Y ☐N

Do you wear glasses? ☐Y ☐N
I , a a ? ☐R ad ☐D a c ☐B

Any communication problems before the stroke/accident/illness?

Indicate any current or previous speech-therapy services since your stroke/accident/illness:

Da :
C, ca :
Fac, :
Add :
P :
E a, :

Da :
C, ca :
Fac, :
Add :
P :
E a, :

Da :
C, ca :
Fac, :
Add :
P :
E a, :

Da :

C ca :

Fac :

Add :

P :

E a :

What are your goals for communication?

Medical Information

List current medications and dosages:

Do you take your medications independently? ☐Y ☐N

I , a d c b :

Do you have any allergies? ☐Y ☐N

I , a d c b :

Are you on a special diet? ☐Y ☐N

I , a d c b :

What was your handedness before the present problem? ☐R ☐L

As a result of your stroke / accident / illness:

Do you have any trouble with swallowing? ☐Y ☐N

I , a d c b :

Do you have trouble with walking? ☐Y ☐N
I , , a d c b : _____

_____

Do you use a wheelchair? ☐Y ☐N
I , d d d , ? ☐Y ☐N

Do you use a cane or walker? ☐Y ☐N

Indicate how far you can walk? ☐25 , ☐25-100 ☐100

Do you have weakness or paralysis of your arm/hand: ☐Y ☐N I , ☐R ? ☐L ?
P , a d c b _____

Are you independent with transfers? ☐Y ☐N
I , , a d c b _____

Are you independent with the bathroom? ☐Y ☐N
I , , a d c b _____

Do you have special transportation requirements?

Are you currently receiving any other therapies (e.g. PT, OT, psychological/ counseling services; vocational rehabilitation services)? ☐Y ☐N
I , , a d ca : _____

_____

T c : _____

Da : _____

C , ca : _____

Fac , : _____

Add : _____

P : _____

T c : _____

Da : _____

C , ca : _____

Fac , : _____

Add : _____

P : _____

T c :

Da :

C, ca :

Fac, :

Add :

P :

Do you have any other long-standing medical issues? ☐Y ☐N

l , , a d c b

Personal Information

Who do you live with (indicate name and relationship)?

Do you have children? ☐Y ☐N

l dca a ada :

Do you have grandchildren? ☐Y ☐N

l dca a ada :

Most recent occupation:

Were you employed at the time of your stroke/accident/illness? ☐Y ☐N

l , ?

Past occupations?

What was your highest level of education:

☐ 8 ad
☐ 9 11 ad
☐ H c ad a
☐ M a 12 a b ac ad a
☐ C ad a (4 a a)
☐ Ad a c dd P a d ca : _____

_____

Is English your first language? ☐ Y ☐ N

Did you ever speak another language fluently? ☐ Y ☐ N

l , c a a ? _____

_____

What kind of leisure activities / hobbies did you enjoy before your stroke / accident / illness?

_____

_____

_____

_____

What kind of leisure activities / hobbies do you enjoy now?

_____

_____

_____

_____

Describe what you do in an average day:

_____

_____

_____

_____

What kinds of activities would you like to be able to do but have di□culty with?

_____

_____

_____

_____

Describe the kind of di□culty you have with these activities:

_____

_____

_____

_____

Primary Contact Information:

Na a , b a c ac :

R , a , a c a :

Add :

C : S a : Z :

P ( ): H C ,, W

E a , :

Da b , : S : ☐F ☐M

Sessions for family members, caregivers and friends are an essential part of the program. These sessions will be scheduled during the first and last weeks of the program.

If the person accompanying you to these sessions is di□erent from the above, please provide his or her name and relationship:

P , a a , a acc a a , c a d a ,, a , a d , dd , .

Are there additional family members, caregivers or friends who are available to attend all or part of the program? ☐Y ☐N

I , , a d ca , a d , a a , ab , :