



Adult Pre-Assessment Form

Your Details

Client	<i>First Name</i>	<i>Surname</i>	
	<i>Birthdate</i>	<i>Occupation</i>	
Address	<i>No. Street</i>	<i>Suburb</i>	
	<i>City</i>	<i>Postcode</i>	
Contact	<i>Home Phone</i>	<i>Work Phone</i>	<i>Mobile</i>
	<i>Email</i>		
Doctor	<i>Name</i>	<i>NHI number</i>	
	<i>Medical Centre/GP Surgery</i>		
Specialist	<i>Name</i>		
Who Do You Live With?	<i>Name</i>	<i>Relationship</i>	

How did you find Vocalsaints?

- Google
- Internet Search
- Facebook
- Brochure
- Other (please state) _____

- Referral (By ↓)**
- Client _____
- Dr _____
- Specialist _____
- School _____
- Other (please state) _____



Medical Background

Have you had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Grommets | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Flu | <input type="checkbox"/> Sleeping difficulties |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Head injury | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colds | <input type="checkbox"/> High fevers | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Sore ears but no infection | <input type="checkbox"/> Measles | <input type="checkbox"/> Vision problems |
| | <input type="checkbox"/> Meningitis | |

If you have had ear infections, please describe how often and how recently:

Have you had other serious injuries or surgery? If yes, please explain:

Are you currently (or have you recently been) under a Specialist's care? Yes No
If yes, with whom and why?

Please list any medications you take regularly:

Do you have any difficulties with eating or drinking? If yes, please explain:

Is your communication difficulty causing issues at home or at work? If yes, please explain:



Home & Family Factors

Is there a language other than English spoken in the home? Yes No

If yes, which one(s): _____

Do you speak the language? Yes No

Do you understand the language? Yes No

Is there a family history of:

- Speech delay or disorder Yes No
- Language delay or disorder Yes No
- Learning difficulties / Dyslexia Yes No
- Intellectual impairment Yes No
- Hearing impairment / grommets Yes No
- Stutter Yes No
- Medical diagnosis, e.g. Down Syndrome, Autism Yes No

Speech Language Therapy

What are your concerns about your speech sounds and/or language skills?

- Speech clarity (i.e. difficult to understand, sound errors, lisp, mumbling)
- Understanding what other people say / following directions
- Expressive vocabulary
- Sentence structure (putting words together appropriately in the right order)
- Use of grammar (e.g. past tense, plurals, pronouns)
- Word retrieval (e.g. delay choosing a word to say, or saying a similar word like 'lion' instead of 'tiger')
- Literacy skills (reading and/or writing)
- Stutter/Dysfluency and/or excessive verbal hesitations or faulters in speech
- Voice quality (e.g. hoarse, husky) or voice volume (e.g. unable to control volume)
- Rate of speech (e.g. consistently talks too fast and is then difficult to understand.)
- Other concerns (or additional details):

Have you ever had speech therapy appointment? Yes No

If yes, when was it and what were you told?

What methods have you tried so far, to help improve your speech/language?



If You Are Concerned About Stuttering

Is there a known family history of stuttering?

Yes

No

When did you first start to notice a stutter: _____

Please provide a description or example of the stutter:

Have you noticed any changes in the stutter since it started?

Yes

No

If yes, please describe:

Is the stutter episodic (coming and going) or continuous (present most of the time you talk)?

Episodic Continuous

What have you tried so far to help improve the stutter? What have found to be helpful and unhelpful?

What do you find helps you? Even if inconsistently?

What advice have you been given?



If You Are Concerned About Voice Quality

How would you describe your voice? E.g., husky, croaky, monotone, crackly.

What comments (if any) have others made about your quality of voice?

How often do you “lose” your voice (i.e. no sound comes out, or it’s much quieter than usual)?

What kinds of environments do you typically speak in?

E.g., indoors, outdoors, noisy, dusty, air conditioned, on the phone, in front of crowds.

Do you consider your job to be stressful?

Yes No

Is singing important to you?

Yes No

Do you participate in any activities that facilitate yelling (e.g. sports teams)?

Yes No

Do you smoke?

Yes No

Have you smoked in the past?

Yes No

What are the top three most common fluids you drink?



Appointments

What would you most like to achieve from this initial appointment?

(e.g.: Gateway to therapy to correct present concerns; to receive advice and guidance; reassurance or confirmation)

What would you most like to achieve from therapy?

Days and times that **would** suit for therapy appointments:

- Monday morning afternoon
- Tuesday morning afternoon
- Wednesday morning afternoon
- Thursday morning afternoon
- Friday morning afternoon
- Saturday morning afternoon (please note that this day is only available in certain locations)

Do you have any current commitments or restraints that may impact on regular engagement in therapy or consolidation of targets between appointments?

E.g., normally living overseas, about to move house, unpredictable job requirements, times of appointments or financial circumstances.

Additional Comments:

Name of the person who completed the form: _____

Signature: _____ Date: _____

The content of this form is so valuable, thank you for taking the time to complete it ready for your first appointment. Please email the completed form to enquires@vocalsaints.co.nz and bring the hard copy along to your appointment.



Client Agreement

I agree that qualified Speech-Language Therapists from Vocalsaints can work with and collect personal information for the benefit of service provision where necessary for:

Name: _____ DOB: _____

The information may be collected by or shared with the following people or agencies:

Name / Organisation

Contact Details:

I understand that, by attending Speech-Language Therapy sessions with Vocalsaints Ltd,

I agree to the following:

- *not* to hold Vocalsaints or its workers liable for my progress or lack thereof.
- to make any payments on the day of service, otherwise I will pay any interest incurred in addition to the original fee, including any necessary collection costs.
- to Vocalsaints' Cancellation Policy: missed appointments or cancellations with less than 24 hours' notice is provided, the original fee is still due unless a doctor's certificate is provided; late payments are also subject to interest accrual.
- to information about myself being used for statistical purposes, provided that the information is used in a way that will not identify me or my family.
- That, for the purpose of collaboration or client handover, an additional qualified Speech-Language Therapist may observe my speech-language therapy sessions from time to time, in addition to my private therapist. The second therapist will be an employee of Vocalsaints.
- that under Principle 3 and 6 of the Privacy Act 1993, I can access personal information collected by writing to Vocalsaints. Updated contact details for Vocalsaints will be held at www.Vocalsaints.co.nz.

Optional Consent:

I give consent to:

- be photographed and/or video recorded for therapy related reasons
- be photographed and/or video recorded for Vocalsaints marketing purposes
- be observed by a Speech-Language Therapy student or person interested in Speech-Language Therapy as a profession from time to time; knowing that sessions will not be disturbed or interrupted by this person
- have Biblically themed activities or references used in therapy

Name: _____ Signature: _____

Date: _____