School of Communication Sciences & Disorders
Andrews University

Bell Hall, Suite 114
Berrien Springs, MI 49104
Phone: (269) 471-3603
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parkinsons@andrews.edu

Speech & Hearing Clinic

Parkinson's Case History Form

Name:_____ DOB: _____ Age:_____ Sex: M □ F □

Address:_____
Street City State Zip

Phone: _____ Hm □ Cell □ Other Phone: _____

Email: _____ Occupation: _____

Name of Person Filling out Questionnaire: _____

Relationship to Client: _____ Today's Date: _____

What is your primary concern? _____

_____

_____

_____

_____

_____

_____

When did you first notice this concern? _____

_____

What do you think was the cause? _____

_____

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Has your voice or speech changed since diagnosis? Yes □ No □

How has your voice or speech changed? _____

_____

_____

Have you had other speech therapy? Yes □ No □ Have you had LSVT? Yes □ No □

Do you wear hearing aids? Yes □ No □ Do you wear eye glasses? Yes □ No □

List Medications. _____

_____

_____

_____

List any medical problems. _____

_____

_____

List any surgeries or accidents. _____

_____

_____

Signature: _____ Date: _____

Print name: _____ Relation to client: _____

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Client Name:_____ Date of Birth:_____

My initials in each box indicates that I understand each statement and agree to receive services under these conditions.

	I understand that Andrews University's Speech & Hearing Clinic is a teaching program. The speech therapy is performed by students under the supervision of a licensed and certified speech-language pathologist.
	Andrews University Speech & Hearing Clinic, SPEAK OUT!® program is a pay-it-forward model. There is no payment required. Donations are accepted.
	I understand that two "no call / no show" therapy sessions can grant Andrews University's Speech & Hearing Clinic the right to dismiss all future services.

Video Release

	I understand SPEAK OUT! requires video recording and I will be informed prior to the session being recorded.
	I understand these recordings may be used for teaching/research within the department.

	I **do not** wish to be recorded.
	By choosing not to be recorded, I understand I will not be able to receive teletherapy through the Andrews University Speech & Hearing Clinic, SPEAK OUT! program.

Print Name_____

Signature_____ Date_____

Relation to client: (Self, Spouse, Child, etc.)_____

The Communicative Participation Item Bank – General Short Form

Instructions:
The following questions describe a variety of situations in which you might need to speak to others. For each question, please mark how much your condition interferes with your participation in that situation. By "condition" we mean ALL issues that may affect how you communicate in these situations including speech conditions, any other health conditions, or features of the environment. If your speech varies, think about an AVERAGE day for your speech – not your best or your worst days.

	Not at all (3)	A little (2)	Quite a bit (1)	Very much (0)
1. Does your condition interfere with... **...talking with people you know?**	○	○	○	○
2. Does your condition interfere with... **...communicating when you need to say something quickly?**	○	○	○	○
3. Does your condition interfere with... **...talking with people you do NOT know?**	○	○	○	○
4. Does your condition interfere with... **...communicating when you are out in your community (e.g. errands; appointments)?**	○	○	○	○
5. Does your condition interfere with... **...asking questions in a conversation?**	○	○	○	○
6. Does your condition interfere with... **...communicating in a small group of people?**	○	○	○	○
7. Does your condition interfere with... **...having a long conversation with someone you know about a book, movie, show or sports event?**	○	○	○	○
8. Does your condition interfere with... **... giving someone DETAILED information?**	○	○	○	○
9. Does your condition interfere with... **...getting your turn in a fast-moving conversation?**	○	○	○	○
10. Does your condition interfere with... **...trying to persuade a friend or family member to see a different point of view?**	○	○	○	○

EAT-10: A Swallowing Screening Tool

Last Name:_____ First Name:_____

Age:_____ Date:_____

Objective: EAT-10 helps to measure swallowing difficulties. It may be important for you to talk with your physician about treatment options for symptoms.

Instructions: Answer each question by writing the number of points in the boxes.

To what extent do you experience the following problems?

Symptom	Score	
My swallowing problem has caused me to lose weight.	0 = no problem 1 2 3 4 = severe problem	Score
My swallowing problem interferes with my ability to go out for meals.	0 = no problem 1 2 3 4 = severe problem	Score
Swallowing liquids takes extra effort.	0 = no problem 1 2 3 4 = severe problem	Score
Swallowing solids takes extra effort.	0 = no problem 1 2 3 4 = severe problem	Score

Swallowing pills takes extra effort.	0 = no problem 1 2 3 4 = severe problem	Score
Swallowing is painful.	0 = no problem 1 2 3 4 = severe problem	Score
The pleasure of eating is affected by my swallowing.	0 = no problem 1 2 3 4 = severe problem	Score
When I swallow food sticks in my throat.	0 = no problem 1 2 3 4 = severe problem	Score
I cough when I eat.	0 = no problem 1 2 3 4 = severe problem	Score
Swallowing is stressful.	0 = no problem 1 2 3 4 = severe problem	Score
		Total Score

Scoring: Add up the number of points and write your total score in the boxes.
Total Score (max. 40 points)

Reference: The validity and reliability of EAT-10 has been determined. Form adapted for use from: Belafsky PC, Mouadeb DA, Rees CJ, Postma GN, Allen, J., Leonard RJ. Validity and Reliability of the Eating Assessment Tool (EAT-10). Annals of Otology Rhinology and Laryngology 2008; 117(12): 919-924.