JODY SASTRY
SPEECH THERAPY

New Client Registration

Today's Date:_____

Client Contact Information:

Name_____

Gender _____

Address_____

City _____ State_____ Zip_____

Best phone number_____

Is this a cell phone? _____

Do you accept text messages for reminders?_____

Do you allow voicemail messages left on this phone?_____

Spouse or Caregiver Contact Information (if applicable)

Name_____

Best Phone Number_____

Is this a cell phone? _____

Do you accept text messages for reminders?_____

Do you allow voicemail messages left on this phone?_____

Alternate Emergency Contact Name/Relationship

_____

Phone _____

Physician Information:

Referring Physician Name _____

Referring Physician Phone _____

Referring Physician Address

_____

21 Marshview Circle, E. Sandwich, MA 02537
Office # 774-413-9099 • **FAX# 844-965-9390**
info@jodysastry.com
www.jodysastry.com

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SPEECH THERAPY

New Client Information:

Occupation:_____

Education:_____

Presently Employed _____Retired _____Unemployed_____

Marital Status: SINGLE _____MARRIED _____WIDOWED_____DIVORCED

Who referred you to Jody Sastry Speech Therapy?

_____

Reason for
referral_____

_____

Please provide a list of places where you have had previous speech evaluations or therapy

NAME:_____
ADDRESS:_____
DATE:_____

NAME:_____
ADDRESS:_____
DATE:_____

NAME:_____
ADDRESS:_____
DATE:_____

Existing or previous diagnosis:

_____

Please describe your present communication problem(s):

_____

_____

_____

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What do you think caused your problem?

_____

_____

_____

Has the problem become worse or has it seemed to improve? Please explain.

_____

_____

What conditions seems to make the problem better or worse?

_____

How does speech affect your job or other aspects or your life that require communication? Please explain (for example, do you withdraw from communicative situations because of your problems, or has it affected your choice of job)?

_____

_____

_____

Do other members of your family have a similar problem or other speech problem? Please explain:

_____

_____

_____

What strategies have you used at home to work on this problem?

_____

_____

Have you received any help for this problem (speech pathologists, doctors or other professionals?) Please explain._____

_____

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Have you had any serious accidents? If so, please explain:

Have you had any chronic illnesses? If so, please explain:

Have you ever been hospitalized? If so, please explain:

Please indicate any surgeries or illnesses related to this speech problem:

Do you have any difficulties with your hearing? Please explain:

Please describe any physical disabilities:

Please list all medications you have been subscribed:

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Please print name of person completing this form:

_____DATE:_____

Signature of person completing this form:

_____DATE:_____

SELF _____SPOUSE _____FAMILY _____OTHER_____

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