Intensive Aphasia Therapy Program Application

Name of participant: _____

Address: _____

Phone(s): Home _____ Work _____

Cell _____

Email: _____

Date of birth: _____ Sex: ☐ F ☐ M

Date of onset: _____ Cause of Aphasia: _____

_____

Communication Information

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

Speech

- ☐ Uses sentences most of the time
- ☐ Puts two or three words together
- ☐ Says words
- ☐ Unable to say words
- ☐ Additional information: _____

Understanding

- ☐ Follows all conversation
- ☐ Understands conversation some of the time
- ☐ Understands and follows short, simple directions
- ☐ Does not usually understand conversation
- ☐ Additional information: _____

Reading

- ☐ Reads books
- ☐ Reads newspapers and magazine articles
- ☐ Reads sentences (e.g. newspaper headlines)
- ☐ Reads words
- ☐ Does not read
- ☐ Additional information: _____

Writing

- ☐ Writes sentences
- ☐ Writes words
- ☐ Writes name and address
- ☐ Does not write
- ☐ Additional information: _____

Math: _____

_____

Other: _____

_____

Has your hearing been tested? ☐ YES ☐ NO If so, when?
Do you wear a hearing aid? ☐ YES ☐ NO
Do you wear glasses? ☐ YES ☐ NO
If so, for what reason? ☐ Reading ☐ Distance ☐ Both

Any communication problems before the stroke/accident/illness?

_____

_____

_____

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

Date: _____
Clinician: _____
Facility: _____
Address: _____
Phone: _____
Email: _____

Date: _____
Clinician: _____
Facility: _____
Address: _____
Phone: _____
Email: _____

Date: _____
Clinician: _____
Facility: _____
Address: _____
Phone: _____
Email: _____

Date: _____
Clinician: _____
Facility: _____
Address: _____
Phone: _____
Email: _____

What are your goals for communication? _____
_____
_____
_____
_____

Medical Information

List current medications and dosages: _____
_____
_____
_____
_____
_____
_____
_____

Do you take your medications independently? ☐ YES ☐ NO
If not, please describe _____

Do you have any allergies? ☐ YES ☐ NO
If yes, please describe _____

Are you on a special diet? ☐ YES ☐ NO
If yes, please describe _____

What was your handedness before the present problem: ☐ Right ☐ Left

As a result of your stroke/accident/illness: _____

Do you have any trouble with swallowing: ☐ YES ☐ NO
If yes, please describe _____

Do you have trouble with walking: ☐ YES ☐ NO

If yes, please describe _____

Do you use a wheelchair? ☐ YES ☐ NO

If so, do you use it independently? ☐ YES ☐ NO

Do you use a cane or walker? ☐ YES ☐ NO

Indicate how far you can walk

☐ 25 meters or less ☐ 25-100 meters ☐ 100 meters or more

Do you have weakness or paralysis of your arm/hand: ☐ YES ☐ NO

If so, ☐ Right? ☐ Left?

Please describe _____

Are you independent with transfers? ☐ YES ☐ NO

If no, please describe _____

Are you independent with the bathroom? ☐ YES ☐ NO

If no, please describe _____

Do you have special transportation requirements? _____

_____

Are you currently receiving any other therapies (e.g. PT, OT, psychological/ counseling services; vocational rehabilitation services)? ☐ YES ☐ NO

If yes, please indicate: _____

Type of service: _____

Dates: _____

Clinician: _____

Facility: _____

Address: _____

Phone: _____

Type of service: _____

Dates: _____

Clinician: _____

Facility: _____

Address: _____

Phone: _____

Type of service: _____
Dates: _____
Clinician: _____
Facility: _____
Address: _____
Phone: _____

Do you have any other long-standing medical issues? ☐ YES ☐ NO
If yes, please describe _____
_____
_____
_____
_____

Personal Information

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

Do you have children? ☐ YES ☐ NO
Indicate names and age: _____
_____
_____
_____

Do you have grandchildren? ☐ YES ☐ NO
Indicate names and age: _____
_____
_____
_____

Most recent occupation: _____

Were you employed at the time of your stroke/accident/illness? ☐ YES ☐ NO
If so, where? _____

Past occupations? _____
_____
_____
_____

What was your highest level of education:

- ☐ 8th grade or less
- ☐ 9th – 11th grade
- ☐ High school graduate
- ☐ More than 12 years but not a college graduate
- ☐ College graduate (4 year program)
- ☐ Advanced degree Please indicate _____

Is English your first language? ☐ YES ☐ NO

Did you ever speak another language fluently? ☐ YES ☐ NO

If yes, which languages? _____

_____

_____

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 difficulty with?

_____

_____

_____

Describe the kind of difficulty you have with these activities: _____

_____

_____

_____

Caregiver Information:

Name of primary caregiver: _____

Relationship to participant: _____

Address: _____

Phone (home; work; cell): _____

Email: _____

Date of birth: _____

Sex: ☐ 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 different from the above, please provide his or her name and relationship: _____

_____

Please also note that accompanying persons are welcome to attend all or part of the program during the middle weeks.

Are there additional family members, caregivers or friends who are available to attend all or part of the program? ☐ YES ☐ NO

If so, please indicate who and his or her availability: _____

_____

_____

_____