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## NEW PATIENT PACKET, VOICE & SWALLOWING

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**If the patient is a minor, please complete the following:**

Your Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Your Address: \_\_\_\_\_

Relationship to patient: \_\_\_\_ Parent \_\_\_\_ Guardian \_\_\_\_ Other (explain) \_\_\_\_\_

I hereby consent to the provision of care, diagnosis and/or treatment by the Ear Institute of Texas, the Voice & Swallow Institute of Texas and/or the Hearing Institute of Texas. This consent shall apply to physicians, non-physician providers, audiologists, and any other employee working under the direction of the physician, or other professional medical care provider, to provide medical care for me (or to the patient). This consent includes contact and discussions with other health care professionals for care and treatment as well as your health insurance plan company.

I understand that I have the right to refuse any diagnostic testing or other recommendations by my health care provider.

**PATIENT RIGHTS**

- To be treated with courtesy and respect and protection of your privacy.
- To prompt and reasonable response(s) to questions and requests.
- To know who is providing your medical care and/or testing at the time of your visit.
- To be provided information concerning diagnosis and treatment.
- To impartial access to medical treatment or accommodations regardless of race, national origin, religion, sexual orientation, gender identity, or handicap.
- The right to privacy and confidentiality of all records pertaining to your treatment.
- To have access to senior management for complaints, compliments, or other clinic related matters.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTICE OF PRIVACY PRACTICES –  
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

**RELEASE OF INFORMATION – MEDICAL PROVIDERS AND YOUR RIGHTS**

(\_\_\_\_) Your confidential information could potentially be transmitted to those who are not authorized to receive such information. **INITIAL** The Ear Institute of Texas uses its best efforts to avoid such disclosure. I have been advised of this potential and authorize the Ear Institute of Texas to utilize facsimile to transmit my Protected Health Information (“PHI”), which may include, without limitation, contact information and medication history.

I hereby authorize the Ear Institute of Texas to release my PHI to the referring physician or to another physician or health care provider or facility associated with my care and treatment, or as otherwise permitted by applicable rules, regulations or laws. I understand and agree that the release of any such information may be transmitted, without limitation; telephonically, by facsimile, electronically, by mail, courier, or by overnight delivery services.

Further I hereby authorize the Ear Institute of Texas to obtain my PHI from the referring physician or another physician or health care provider or facility associated with my care and treatment including medication history from any pharmacy and that any such PHI information may be transmitted to the Ear Institute of Texas, without limitation, telephonically, by facsimile, electronically, by mail, courier, or by overnight delivery services.

You may ask to see or receive a copy of your medical records and other health information. If you want a copy, you will need to put your request in writing, there could be a small fee to cover the cost of printing and postal services. It may take up to but not exceed 30 days. You may request to change any incorrect information in your file or add information to your file if you think something is missing or incomplete.

If you believe your privacy rights have been violated, you may file an OCR complaint with us or the Secretary of Health and Human services. Under HIPAA, we cannot retaliate against anyone for filing a complaint.

You have the right to request a copy of this notice from us at any time.

**RELEASE OF INFORMATION – FAMILY AND OTHERS**

(\_\_\_\_) In accordance with HIPAA regulations, the Ear Institute of Texas may not discuss your condition, care, or treatment plan with **INITIAL** family members or other individuals unless that person(s) is authorized by you to access any such PHI information in regard to your condition, care or treatment plan. Any such authorization must be obtained by the Ear Institute of Texas, from you or your legally authorized representative, prior to the release of any such information.

However, pursuant to the regulations, this privacy provision may be waived dependent upon your medical condition.

**Therefore I do hereby authorize the Ear Institute of Texas to release my PHI to the following person(s)**

\_\_\_\_\_  
**Name** Relationship

\_\_\_\_\_  
**Name** Relationship

**EMERGENCY CONTACT(s): Contact Person Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Emergency Contact Phone Number(s): Mobile:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**General disclosure:** Dr. Jackson functions as investor or in advisory role for the following companies: Precision Neuromonitoring, Astute Assistants, and Cochlear Corporation.

**I have read this release before signing below and I fully understand the contents, meaning and impact of this release.**

\_\_\_\_\_  
**Signature: Patient/Guarantor/Legal Guardian**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Print Name: Patient/Guarantor/Legal Guardian**

\_\_\_\_\_  
**Date**

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to the Ear Institute of Texas and the Voice & Swallowing Institute of Texas as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

**Signature: Patient/Guarantor/Legal Guardian**

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**Date**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

# HEALTH HISTORY

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Chief Complaint/Reason for today's visit: \_\_\_\_\_

**No change since my last visit. Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Do you experience tinnitus (ringing in your ears)? Yes No Do you experience dizziness? Yes No

## List ALL Surgeries

Year

Complications

List ALL Surgeries	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had: Pneumonia vaccination within the last 5 years? Y/N Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Flu shot in the last year? Y/N Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had: Mammogram? Y/N Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pap Smear? Y/N Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Colonoscopy? Y/N Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**RESULTS: Mammogram:** \_\_\_\_ Normal \_\_\_\_ Abnormal \_\_\_\_ **Pap Smear:** \_\_\_\_ Normal \_\_\_\_ Abnormal \_\_\_\_ **Colonoscopy:** \_\_\_\_ Normal \_\_\_\_ Abnormal \_\_\_\_

**\*\*\*ALLERGIES TO MEDICATION: None** \_\_\_\_ **Please list any known allergies** \_\_\_\_\_

Have you ever had problems with anesthesia? Yes \_\_\_\_ No \_\_\_\_ If yes, what problems: \_\_\_\_\_

## Past Medical History

Have you ever had the following: (Circle "yes" or "no", leave blank if uncertain)

Pacemaker	Yes No	Bleeding Tendency	Yes No	Asthma	Yes No	Diabetes I or II	Yes No
Meningitis	Yes No	High Blood Pressure	Yes No	Hives or Eczema	Yes No	High Cholesterol	Yes No
Spine/Back Problems	Yes No	Low Blood Pressure	Yes No	AIDS or HIV+	Yes No	<b>Please list ALL other illnesses,</b>	
Arthritis	Yes No	Heart Disease (Besides BP)	Yes No	Stroke	Yes No	past or present: _____	
Epilepsy	Yes No	If yes, what type (Circle all that apply):		Hepatitis A/B/C	Yes No	_____	
Migraine Headaches	Yes No	A.Fib; Coronary Artery Disease;		Kidney Disease	Yes No	_____	
Other Headaches	Yes No	Heart Attack;Valve Issues; Other: _____		Thyroid Disease	Yes No	_____	
Cancer	Yes No	Cancer treatments (Check all that apply): Surgery _____ Radiation _____ Chemo _____					
Type/Location: _____		Are you cancer free at this time? Yes No					

## Patient Social History

Occupation: \_\_\_\_\_

Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Do you have children: Yes \_\_\_ No \_\_\_ If yes, how many? \_\_\_\_\_ Lives with you? Yes No

Do you smoke? Yes \_\_\_ No \_\_\_ I quit \_\_\_ years ago If you have smoked: \_\_\_ packs of cigarettes per day for \_\_\_ years.

Do/ Did you use any other form of tobacco/nicotine: Yes No What type: \_\_\_\_\_ How much: \_\_\_\_\_ For how long: \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ No, but I used to \_\_\_\_\_

If yes, how often? Daily: \_\_\_/day 1 or more times a week: \_\_\_/week 1 or more times a month: \_\_\_/month Rarely \_\_\_\_

## Family Medical History

Please circle any of the following which have occurred in an immediate family member (parent, sibling, and children only - not by marriage/adoption)

**For any circled, list relation (mother, father, etc.) and specific condition/symptoms below; if none, check here** \_\_\_\_\_

Epilepsy	Relation: _____	Asthma Relation: _____	Stroke Relation: _____	Migraines Relation: _____
Ear Problems	Relation: _____	Kidney Disease Relation: _____	Thyroid Disease Relation: _____	Heart Disease Relation: _____
High Blood Pressure	Relation: _____	Low Blood Pressure Relation: _____	Hemophilia Relation: _____	Diabetes Relation: _____

Is there a history of hearing loss, dizziness, or ear problems in the family? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe relation and condition: \_\_\_\_\_

**Current Medications** None:  **See Attached List:**

Please list all medications. If more space is needed, please attach an additional sheet of paper

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Preferred Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**How did you hear about us?** (Circle one) Friend Internet Ad Doctor: \_\_\_\_\_ Other: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Review of Systems: Please indicate any personal history below:

**Constitutional / General**

Fever Yes No  
Weight Loss Yes No  
Night Sweats Yes No  
Excessive Fatigue Yes No

**Eyes**

Wear Glasses Yes No  
Infections Yes No  
Injuries Yes No  
\*Glaucoma Yes No  
\*Cataracts Yes No  
If yes, operated? ( right/left ) Yes No  
\*Macular Degeneration Yes No  
Itchy/watery eyes Yes No

**Ear**

Wear Hearing Aids Yes No  
Hearing Loss Yes No  
If yes, circle one of the following:  
*Left / Right / Both Sides*  
*Rarely / Occasional / Constant*  
Ear Pain Yes No  
Ringing in the Ears Yes No  
If yes, circle one of the following:  
*Left / Right / Both Sides*  
*Rarely / Occasional / Constant*  
Dizziness Yes No  
If yes, circle one of the following:  
*Spinning Vertigo / Lightheadedness / Imbalance*  
Exposure to Loud Noise Yes No  
If yes, list: \_\_\_\_\_

**Nose, Throat, and Mouth**

Nose Bleeds Yes No  
Nasal Congestion Yes No  
Inability to Smell Yes No  
Sinus Problems Yes No  
Sinus Headaches Yes No  
Sore Throat Yes No  
Hoarseness Yes No  
Difficulties Swallowing Yes No  
Speech Delay/Difficulties Yes No  
Pain Swallowing Yes No

**Respiratory**

Chronic Cough Yes No  
\*Emphysema Yes No  
Shortness of Breath Yes No  
\*Bronchitis Yes No  
\*Pneumonia Yes No  
Lung Cancer Yes No  
Blood Sputum Yes No

**Cardiovascular**

Chest Pain or Angina Yes No  
Irregular Pulse Yes No  
\*Heart Murmur Yes No  
Swelling in Feet or Hands Yes No  
Leg Pain While Walking Yes No

**Musculoskeletal**

Broken Bones Yes No  
Arm or Leg Weakness Yes No  
Back Pain Yes No  
Arm or Leg Weakness Yes No  
Joint Pain or Swelling Yes No

**Integumentary**

Skin Disease Yes No  
Skin Cancer Yes No

**Gastrointestinal**

Indigestion/Pain with Eating Yes No  
Nausea Yes No  
Vomiting Yes No  
\*Liver Disease Yes No  
Jaundice Yes No  
Abdominal Pain Yes No  
\*Ulcers or Gastritis Yes No  
Colon Cancer Yes No  
Heartburn Yes No  
Reflux Yes No

**Genitourinary**

Urinary Tract Infections Yes No  
Blood in Your Urine Yes No  
Incontinence Yes No  
Prostate Cancer (males) Yes No  
\*Endometriosis (females) Yes No  
Uterine/Cervical Cancer Yes NO

**Hematologic/Lymphatic**

\*Anemia Yes No  
\*Hemophilia Yes No  
Persistent Swollen Glands Yes No  
Swollen Lymph Nodes Yes No  
Blood Transfusion Yes No  
If yes, when? \_\_\_\_\_

**Psychiatric**

\*Anxiety Yes No  
\*Depression Yes No  
\*Bipolar Disorder Yes No  
Other Psychiatric Disorder Yes No  
If yes, please list: \_\_\_\_\_

**Endocrine**

Increased Appetite Yes No  
Excessive Thirst/Urination Yes No  
Hormone Problems Yes No

**Allergic/Immunologic**

\*Immunological Disorders Yes No  
Food Allergies Yes No  
\*Inhalant Yes No  
\*Previously allergy tested? Yes No

**Neurological**

Fainting Spells/Black Outs Yes No  
\*Seizures Yes No  
Problems with Memory Yes No  
Disorientation Yes No  
Difficulty with Your Speech Yes No  
Inability to Concentrate Yes No  
Double or Blurred Vision Yes No  
Face Weakness Yes No  
Poor Coordination in Arms and/or Legs Yes No  
Weakness in Arms or Leg Yes No  
Numbness, tingling or increased sensitivity in your feet? Yes No  
Pain, burning or feelings of pins/needles in your feet? Yes No  
\*Neuropathy Yes No

**For pediatric patients only :**  
Birth History: Full term \_\_\_\_ Premature \_\_\_\_ ( \_\_\_\_ weeks early) Vaginal Delivery \_\_\_\_ Caesarian Section \_\_\_\_  
Complication at Birth: Yes / No Required ICU care \_\_\_\_ Required ventilator \_\_\_\_ Had jaundice \_\_\_\_  
Immunizations: Up to date \_\_\_\_ Not Current \_\_\_\_

I understand that providing incorrect information may be detrimental to my health. Please inform this office of any changes in your medical status/condition. I hereby authorize the healthcare staff to perform any necessary services I may require.

Signature of Patient, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Review**

Signature of Doctor:: \_\_\_\_\_ Date: \_\_\_\_\_



# The Ear Institute of Texas, P.A.

(210) 696-HEAR (4327) • (210) 798-2509 Fax

18518 Hardy Oak Blvd, Suite 300

San Antonio, Texas 78258

## PATIENT INFORMATION

DATE: \_\_\_\_\_ CHART # \_\_\_\_\_

Full Legal Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell:( ) \_\_\_\_\_

E-mail.: \_\_\_\_\_ Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status: \_\_\_\_\_

**Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**How did you find us:** Doctor's Referral | Phone Book | Insurance Provider List | Web-Page | Friend | Other \_\_\_\_\_

**Referring Physician's Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Is your referring physician an Ear, Nose, Throat Specialist? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Primary Care/ Family Physician** \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

## INSURANCE INFORMATION (Disregard if patient is same as policy holder)

**Primary Insurance Company** \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## GUARANTOR OR RESPONSIBLE PARTY FOR PATIENT'S FINANCIAL OBLIGATIONS, \*\*\*NOT YOUR INSURANCE COMPANY\*\*\*

Full Legal Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Phone Number: ( ) \_\_\_\_\_ Home Phone Number: ( ) \_\_\_\_\_

Alternate Phone Number: ( ) \_\_\_\_\_

## IN CASE OF EMERGENCY:

Contact Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone Number: ( ) \_\_\_\_\_ Home Phone Number: ( ) \_\_\_\_\_

**Federal Statistical Information:** Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

# PATIENT INFORMATION

**Patient Policy:** Payment is required at the time of service unless prior arrangements were made. Payment includes any and all applicable co-pays, co-insurance, or deductibles. For your convenience, this office accepts Visa, MasterCard, Debit cards, cash and local checks. There is a \$35.00 service fee for returned checks. ( ) Initials

**Services Not Covered:** At the time of your appointment, you may be required to undergo diagnostic testing which may or may not be covered by your insurance provider. Any charges not covered by your insurance provider will be your responsibility. You will be responsible for payment of these charges at the time the services are provided. ( ) Initials

**Insurance:** This office bills participating insurance companies as a courtesy to our patients. You are expected to submit payment for all applicable co-pays, co-insurance, or deductibles at the time services are rendered, based on the requirements of your individual insurance plan. **If payment is not received from your insurance company, the total balance due will be your responsibility.** **Due to the various insurance plans, we ask that you verify your individual benefits with your insurance provider. This office provides your plan information as a courtesy only and is not responsible for interpretation of your individual plan. I hereby authorize this office to release all medical information to my health insurance provider in order to process my claim; and, I hereby assign all health insurance plan reimbursements to this office.** ( ) Initials

**Missed Appointments:** This office is committed to providing quality services to as many patients as possible. Resources are assigned for each individual patient. Missed appointments (including being 15-minute or more late for your scheduled appointment or not arriving in time to complete your paperwork prior to the scheduled appointment time) represent a cost to this office and are an inconvenience to other patients who could have been scheduled for your assigned time slot. **WE REQUIRE A 24-HOUR NOTICE TO CANCEL YOUR SCHEDULED APPOINTMENT, 48-HOURS TO CANCEL YOUR VESTIBULAR TESTING AND 72-HOURS TO CANCEL YOUR SURGERY.** ( ) Initials

**The cancellation fees are:** \$50.00 for an appointment, \$75.00 for vestibular testing and \$250.00 for surgery (canceled in less than 72-hours prior to your scheduled time) and \$500.00 (if canceled less than 24-hours prior to your scheduled time). These fees may also apply to patients who are more than 15 minutes late for their scheduled appointment. ( ) Initials

**Mid-Level Providers:** Dr. Jackson employs mid-level providers (physician assistant and/or nurse practitioner) to support him in caring for the high volume of patients requiring medical care each day. The mid-level providers are highly qualified and trained by the doctor to treat the medically complex patients seen by the doctors. Patients may be seen by either the physician or one of the mid-level providers. The individual doctor supervises the care of each of their patients but do require assistance to provide care in a timely manner. In some instances, the mid-level provider will begin evaluation of a patient on the doctor's schedule. You may request to see the doctor, if necessary. ( ) Initials

**Please initial each item above and sign/date this form prior to your first visit. Feel free to ask our reception staff or the office manager should you have any questions regarding the information contained within this form. Thank you for being our valued patient!**

Patient/Guarantor/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Printed Name: \_\_\_\_\_

## EAT-10

Swallowing issues, Dysphagia

Circle the appropriate response. To what extent are the following scenarios problematic for you?

0 = No Problem

4 = Severe Problem

My swallowing problem has caused me to lose weight	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals	0	1	2	3	4
Swallowing liquids takes extra effort	0	1	2	3	4
Swallowing solids takes extra effort	0	1	2	3	4
Swallowing pills takes extra effort	0	1	2	3	4
Swallowing is painful	0	1	2	3	4
The pleasure of eating is affected by my swallowing	0	1	2	3	4
When I swallow food sticks in my throat	0	1	2	3	4
I cough when I eat	0	1	2	3	4
Swallowing is stressful	0	1	2	3	4

Total: \_\_\_\_\_

Name (print): \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## RSI

Dysphagia, Reflux, Globus, Sore Throat

Within the last month, how did the following problems affect you? Circle the appropriate response:

0 = No Problem

5 = Severe Problem

Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or postnasal drip	0	1	2	3	4	5
Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5
Coughing after you ate or after lying down	0	1	2	3	4	5
Breathing difficulties or episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Total: \_\_\_\_\_

Name (print): \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## VHI-10

These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0 = never

1 = almost never

2 = sometimes

3 = almost always

4 = always

My voice makes it difficult for people to hear me	0	1	2	3	4
People have difficulty understanding me in a noisy room	0	1	2	3	4
My voice difficulties restrict personal and social life	0	1	2	3	4
I feel left out of conversations because of my voice	0	1	2	3	4
My voice problem causes me to lose income	0	1	2	3	4
I feel as though I have to strain to produce voice	0	1	2	3	4
The clarity of my voice is unpredictable	0	1	2	3	4
My voice problem upsets me	0	1	2	3	4
My voice makes me feel handicapped	0	1	2	3	4
People ask, "What's wrong with your voice?"	0	1	2	3	4

Total: \_\_\_\_\_

Name (print): \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

— FOR SINGERS ONLY —

**SINGING VHI-10**

These are statements that many people have used to describe their singing and the effects of their singing on their lives. Circle the response that indicates how frequently you have had the same experience in the last 4 weeks.

0 = never

1 = almost never

2 = sometimes

3 = almost always

4 = always

It takes a lot of effort to sing	0	1	2	3	4
I am unsure of what will come out when I sing	0	1	2	3	4
My voice "gives out" on me while singing	0	1	2	3	4
My singing voice upsets me	0	1	2	3	4
I have no confidence in my singing voice	0	1	2	3	4
I have trouble making my voice do what I want it to	0	1	2	3	4
I have to "push it" to produce my voice when singing	0	1	2	3	4
My singing voice tires easily	0	1	2	3	4
I feel something is missing in my life because of my inability to sing	0	1	2	3	4
I am unable to use my "high voice."	0	1	2	3	4

Total: \_\_\_\_\_

Name (print): \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_