

Parkinson Voice Project Intake Form

This form is for Texas patients only.

SPEAK OUT!® Therapy Is Best Completed On A Computer, Laptop, Or iPad. Mobile Phones Should Not Be Used For Therapy Sessions.

I have access to a computer, laptop, or iPad for SPEAK OUT! Therapy *(Required)*

Yes

If no, call us: 469-375-6500

Expectations: *(Required)*

I understand that I am expected to practice twice daily, every day during SPEAK OUT! Therapy.

I understand that I need to dedicate a quiet, consistent space to complete SPEAK OUT! Therapy.

Your First Name *(Required)*

Your Last Name *(Required)*

Date of Birth *(Required)*

mm/dd/yyyy

Gender *(Required)*

Male

Female

Address *(Required)*

City *(Required)*

State *(Required)*

Zip Code *(Required)*

Missouri



Best Phone *(Required)*

Best Email *(Required)*

Referred to clinic by (please check one box): *(Required)*

Physician

Family

Friend

Healthcare provider

SPEAK OUT!® Graduate

Social media

Google search

Community event

Our website

Primary Diagnosis *(Required)*

Date Diagnosed (mm/dd/yyyy) *(Required)*

Neurologist Name *(Required)*

Neurologist Phone *(Required)*

Have you been hospitalized in the last year? *(Required)*

Yes

No

Relationship Status: *(Required)*

Single

Married

Widowed

Patient Resides:

Alone

With Spouse/Family

Patient Interests/Hobbies

Employment Status: *(Required)*

Currently Employed

Retired

Current or Previous Occupation *(Required)*

Have you received speech or swallowing therapy in the past? *(Required)*

Yes

No

If so, when?

Where?

Primary focus of therapy?

Was the therapy helpful?

Yes

No

Have you noticed changes in your swallowing? *(Required)*

Yes

No

Have you had a Modified Barium Swallow Study in the last year? (If yes, please send us a copy of the report.) *(Required)*

Yes No

Have you ever had aspiration pneumonia? *(Required)*

Yes No

Check all that apply: *(Required)*

Vocal Nodules/Lesions

Vocal Fold Paralysis

Stroke

Respiratory Issues

Deep Brain Stimulation

Head Injury/Concussion

GERD

Chronic Cough

Light Headedness/Dizziness

Seasonal Allergies

Dry Mouth

Multiple Falls

None

#1 Emergency Contact - Name *(Required)*

Relationship *(Required)*

Best Phone *(Required)*

Best Email *(Required)*

May we discuss your health information with this person? *(Required)*

Yes No

#2 Emergency Contact - Name

Relationship

Best Phone

Best Email

May we discuss your health information with this person?

Yes

No

To Receive Services From Parkinson Voice Project, Please Acknowledge The Following:

Parkinson Voice Project is a unique nonprofit clinic. Since 2008, all our speech therapy has been provided using "Pay It Forward." You will never receive a bill from our clinic. When you complete SPEAK OUT! Therapy, you will have the opportunity to Pay It Forward - make a donation to help the next patient receive speech therapy. *(Required)*

I acknowledge

Parkinson Voice Project staff cannot provide one-on-one mobility assistance. If I have impaired mobility, I must use *(Required)* an appropriate assistive device and/or have a care partner with me in the clinic to ensure my personal safety and to decrease the risk to others.

I acknowledge

Parkinson Voice Project utilizes a HIPAA-compliant web-based platform to provide teletherapy services. *(Required)*

I acknowledge

Please read the following statements. Check each box to express agreement. *(Required)*

Parkinson Voice Project may use my photo, video, and written testimonial about SPEAK OUT! Therapy to train speech-language pathologists to educate other patients and families about SPEAK OUT! Therapy.

Parkinson Voice Project may release speech therapy related information to my neurologist.

Parkinson Voice Project may obtain speech therapy related records from my healthcare provider(s).

I agree that the information provided is accurate and complete to the best of my knowledge. *(Required)*

I agree

Type Name as Signature *(Required)*

Date (mm/dd/yyyy) *(Required)*