

Name: _____ Date: _____

Aphasia - Memory Loss - Speech - Part 1a

Primary Complaint

Instructions: There are six (6) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for your future should this condition continue.

Mark the Primary Complaint: Aphasia Memory Loss Speech-Language disorder
If previously diagnosed condition please name or from the group below identify your main complaint.

Indicate all abnormalities that occur simultaneously with your main complaint:

- | | | | | | |
|-------------------------------------|-------------------------------------|---|--------------------------------------|--|--|
| <input type="checkbox"/> Balance | <input type="checkbox"/> Appetite | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Energy | <input type="checkbox"/> Addiction | <input type="checkbox"/> Injury (Past) |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Defecation | <input type="checkbox"/> Cardio | <input type="checkbox"/> Libido | <input type="checkbox"/> Attitude change | <input type="checkbox"/> Injury (Recent) |
| <input type="checkbox"/> Smell | <input type="checkbox"/> Digestion | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Menses | <input type="checkbox"/> Behavior change | <input type="checkbox"/> Fertility |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Thirst | <input type="checkbox"/> Skin | <input type="checkbox"/> Semen flow | <input type="checkbox"/> Cravings | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Swallowing | <input type="checkbox"/> Urination | | <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotions | <input type="checkbox"/> Pain (physical) |
| <input type="checkbox"/> Taste | <input type="checkbox"/> Bleeding | | <input type="checkbox"/> Excess naps | <input type="checkbox"/> Mental function | <input type="checkbox"/> Twitching-Ticks |
| <input type="checkbox"/> Touch | <input type="checkbox"/> Mucus flow | | | <input type="checkbox"/> Memory | <input type="checkbox"/> Hiccups |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Swelling | | | <input type="checkbox"/> Pain & Emotions | |

Is the current episode the first time this primary complaint has occurred? Yes No, it has occurred _____

When did the primary complaint become disruptive to your Activities of Daily Living or caused significant impairment?

_____ *How many days, weeks, months or years ago or the date.*

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

_____ *Indicate the number of days, weeks, months or years or the date.*

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

_____ *Indicate number of minutes, hours in a day or number of days/weeks*

What do you think is the origin or cause of the primary complaint? _____

What provides relief to the primary complaint? _____

Type of Aphasia:

- Expressive (non-fluent)
- Receptive (fluent)
- Anomic
- Global
- Primary progressive
- Mixed Expressive-Receptive

Speech Disorder:

- Stuttering
- Phonological disorder
- Language disorder
- Unspecified Communication disorder

Other Issues:

- Tongue impairment
- Headaches
- Migraine
- Excess saliva
- Vision impairment
- Hearing Loss
- Cognitive impairment
- Other: _____

Memory Loss:

- Short-term
- Long-term
- Visual

Frequency of occurrence:

- Constant
- Intermittent

Aggravated by:

- Cold Heat
- Physical activity
- Emotional upset
- Stress Weather

Highest Education:

- 6th Grade
- 9-12th grade or Trade Sch
- Associate Degree
- Bachelor Degree
- or Higher

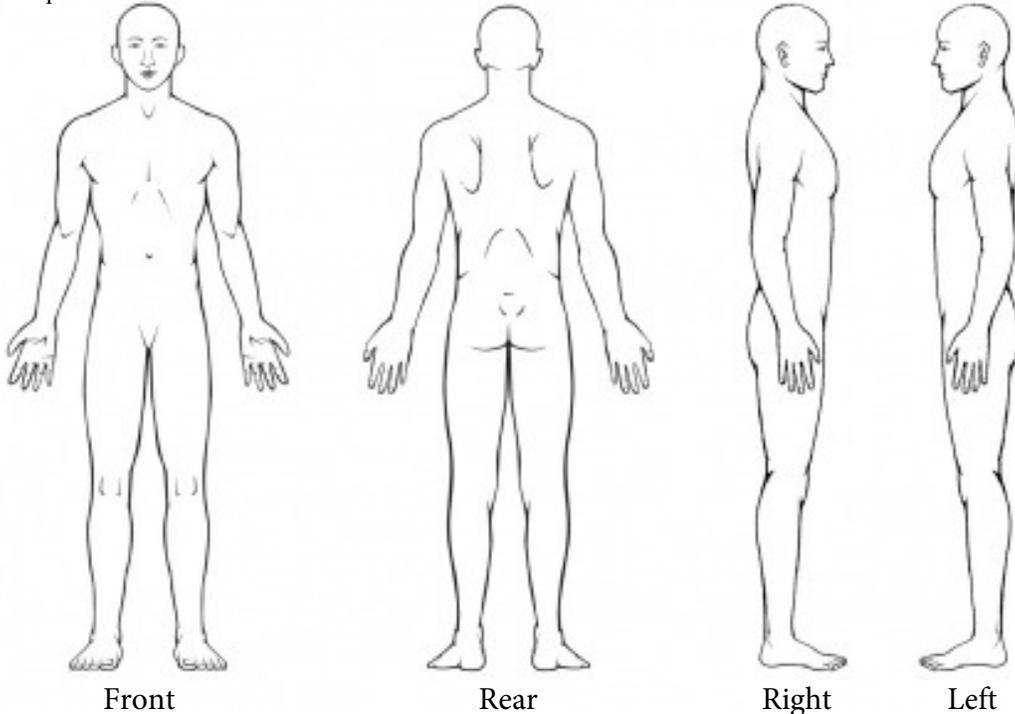
If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Aphasia Speech Memory Part 1a

Name: _____ Date _____

Aphasia-Memory-Speech - Part 1c

Secondary Complaint

Instructions: The images below are covered with Fill-In boxes. Locate on the image where you experience Pain (P), Numbness(N), Tingling(T), Motor dysfunction(Md), location of Injury(I) or Other symptoms(Os) and mark with the letter. Example: "P" for pain



Type of Pain or Sensation:

- Sharp
- Shooting
- Throbbing
- Burning
- Dull
- Aching
- Tingling
- Numbness
- Cramping
- Tightening
- Stiffness
- Swelling
- Heat
- Cold
- Crawling
- Itching

Quality of Primary Complaint:

- Constant
- Intermittent
- Fixed
- Moving

Trigger or Aggravated by:

- Cold
- Physical activity
- Emotional upset
- Stress
- Heat
- Moving
- Upset
- Weather

Rate your pain at it's most and least painfulness:

- 0 None
- 1 Mild - nagging, annoying, interferes little with ADLs
- 2 Mild - nagging, annoying, interferes little with ADLs
- 3 Mild - nagging, annoying, interferes little with ADLs
- 4 Moderate - Interfere's significantly with ADLs
- 5 Moderate - Interfere's significantly with ADLs & need OTC med
- 6 Moderate - Interfere's significantly with ADLs & need OTC med
- 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- 10 Severe - Disabling, unable to perform ADLs & Need hospital

- Are you hands or feet too sensitive to touch? Yes No
- Does it hurt at night when bed covers touch? Yes No
- Do your symptoms worsen at night? Yes No
- Do your legs feel weak when you walk? Yes No
- Do your legs/feet hurt when you walk? Yes No
- Are your feet skin dry and crack open? Yes No
- Can your feet discern hot/cold water in tub/shower? Yes No
- Do your legs/feet experience 'asleep feeling' or loss of sensation?
Yes No
- Are you unable to sense you feet when you walk? Yes No
- Do you have sharp, stabbing or shooting pain in our feet? Yes No

What provides relief of Pain or sensation? _____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
 Example: John_Doe_Physical Sensation Part 1b

