Speech-Language Therapy  
PARKINSON’S DISEASE REFERRALS  
Patient Intake Questionnaire

Name: ___________________________ Date of Birth: ___________________________
Today’s Date: _____________________ Age: ___________________________
Referring Physician: __________________ Primary Dr: __________________________
Neurologist: ____________________________ Physical Therapist: __________________
Date of PD diagnosis: __________________

1. How would you describe your health today?    Excellent    Very Good    Fair    Poor
2. Are you 65 or older?    Yes    No
3. Have you had 2 or more falls in the past year?    Yes    No
4. Have you had any injury from a fall in the past year?    Yes    No
5. What were your initial symptoms of Parkinson’s? __________________________________________

6. Does your Parkinson’s medication affect your voice or speech? Yes    No
   If yes, please explain: _____________________________________________________________

7. Do you experience on/off symptoms? Yes    No
   If yes, please explain: _____________________________________________________________

8. Do you experience dyskinesias? Yes    No
   If yes, please explain: _____________________________________________________________

9. Circle if you have had any of these surgical interventions:
   Deep Brain Stimulation    Neck/throat surgery
10. Diagnostic Tests: CT    MRI    Xray    Swallow Test    Endoscopy    Neuropsychological Test    Other:_____________________________

11. Do you have any other medical problems? Yes    No
    If yes, please explain: _____________________________________________________________

12. What is your most significant problem communicating today? __________________________

13. What do you do when you want to be as easy to understand as possible? _________________

14. Has Parkinson’s disease caused you to talk less? Yes    No
    If yes, please explain why: _______________________________________________________

15. Do you think you run out of breath during speech? Yes    No
16. Have you noticed if your voice is monotone in pitch? Yes    No
17. Have you had any speech therapy before?  

Yes  
No

If yes, what did you work on?________________________________________________________

Speech/Language- Please check the box if you are having challenges in any of these areas:

- decreased articulation
- frequent repetitions of what you have said
- hesitations while speaking
- pragmatics: e.g. using the appropriate tone, taking turns, etc.
- slurred speech
- spelling
- reading comprehension
- weakness - mouth
- weakness - lips
- word retrieval
- writing
- unable to follow directions or understand conversations

Cognitive:

- attention/concentration
- cognitive overwhelm
- fatigue
- goal-setting
- information processing
- limit-setting
- Memory- long term
- Memory – short term
- multitasking
- organization
- pacing and prioritizing
- problem solving
- return to work
- return to school
- self awareness
- task initiation and completion
- time management
- verbal expression

Voice:

Are you a professional voice user (e.g. teacher, singer)?:  

Yes  
No

If yes, describe: _________________________________________________________________

- Hoarseness
- Breathy vocal quality
- Chronic cough or excessive throat clearing
- Vocal strain or fatigue
- Inability to speak loudly
- Loss of voice
- Reduced pitch range or sudden change in overall pitch
- Sudden or gradual change in overall vocal quality
- Tremulous quality in the voice
- Diplophonic (double-toned) quality
- Decreased breath support during speech

Current Nutrition Status:

- Regular diet for solid food
- Regular liquids
- Modified diet (e.g. soft or chopped foods only)
- Thickened liquids:
  - Nectar-thick
  - Honey-thick

No oral intake:

- PEG
- NG/Dobhoff
- Other
How much of your daily intake do you eat by mouth?

ALL  MORE THAN HALF  HALF  LESS THAN HALF  NONE

How much of your daily intake comes through a feeding tube?

ALL  MORE THAN HALF  HALF  LESS THAN HALF  NONE

Do you frequently use straws with liquids?  Yes  No

Do you avoid certain foods because of your swallowing difficulties?  Yes  No

If yes, please explain: ____________________________________________

Does it take you longer to eat a meal than others?  Yes  No

When do you have difficulty at mealtimes?  Beginning  Middle  End  Throughout

How frequently do you have trouble?  All the time  Sometimes  Occasionally

**Swallowing** - Please check the box if you are having challenges in any of these areas:

- Chewing
- Choking while eating/drinking
- Coughing on liquids
- Coughing on solids
- Difficulty with pills
- Frequent throat clearing
- Food left in mouth after swallow
- Feel full after eating small amounts
- Frequent belching
- Increased coughing after meals
- Increased coughing at night
- Irregular bowel movements
- Losing control of food/ mouth spillage
- Memory or cognitive changes
- Nasal spillage of food/liquid
- Need multiple swallows
- Regurgitation
- Saliva management/drooling
- Sensation of food stuck: Where?___________
- Sinus drainage
- Ulcers/Sores in mouth
- Weakness- mouth
- Weakness – lips
- Wet/gurgly voice during or after meal
- Thick or stubborn secretions in the mouth or throat

**Reflux history**  Yes  No

Diagnosis:

- Gastroesophageal reflux disease (GERD)
- Laryngopharyngeal reflux (LPR)
- Other

Symptoms: __________________________________________________________

Frequency of symptoms: ____________________________________________

Are you:  Right handed  Left handed

**Home/ Social/ Community**

1. Home Situation:  house  apartment  condo/townhome
2. Where:  Boulder  Broomfield  Lafayette  Louisville  Erie
   Other:___________
3. Relationship status:  single  married  divorced  dating
4. Who do you live with?__________________________________________
5. Children:  yes  no  Grandchildren:  yes  no
6. Pets:__________________________________________________________
**Education/Occupation**

1. Are you currently working or going to school?  Yes  No  Retired  On Disability
2. Education:  GED  high school  some college  Bachelor’s  Master’s  PhD  Tech/Vocational
3. What is/was your area of study? __________________________________________
4. Learning Style (circle all that apply): Doing  Visual  Listening  Reading/Written handouts
5. What do you do for work? __________________________________________
6. How many hours do you work per week? __________________________________________
7. Did you take any time off from work?  Yes  No  
   If yes, how long? Why? __________________________________________

8. Do you volunteer? Describe: __________________________________________

9. Hobbies/Interests/Social Life: __________________________________________

10. What do you do for exercise? __________________________________________

11. How often? __________________________________________

**Physical:**
- decreased balance
- decreased endurance
- headaches
- Jaw pain/TMJ
- nausea
- pain
- paralysis
- vertigo

**Psychosocial/Emotional:**
- anxiety
- anger control/temper outbursts
- change in sex drive
- depression
- driving anxiety
- flashbacks
- easily upset or angry, cries easily
- frustration
- grief and loss issues
- irritability
- panic attacks
- relationship difficulties
- sleep problems
- stress

1. Who is part of your support system? __________________________________________

2. How are they helping you? __________________________________________

3. Have you participated in mental health therapy or counseling before?  Yes  No
Home Management:
Check challenging home tasks:
- Childcare
- Cleaning
- Cooking
- Grocery Shopping
- Laundry
- Paperwork
- Medication management

Who is helping you with your challenges?

Sleep:
Check the words that describe your sleep
- No problems
- Awaken fatigued
- Difficulty falling asleep
- Intermittent awakening
- Insomnia
- Nightmares

1. Do you take sleep medication? If so, what do you take?
2. Do you take naps? Yes No How many per day?
3. Have you been diagnosed with: Sleep Apnea Narcolepsy
4. How many hours of sleep do you usually get?
5. What time do you usually go to bed? What time do you wake up?

Appetite:
Check all that apply:
- Same – no problems
- No appetite
- Increased appetite
- Decreased appetite
- Forget to eat
- Gained weight
- Lost weight
- Decreased sense of taste or smell
- Special diet:

# of meals/day # of snacks

Substance Use:
1. # Caffeinated drinks
2. Do you drink alcohol? Yes No
If yes: # of alcoholic drinks Per day Weekly Socially
3. Do you smoke tobacco? Yes No
4. Do you use any recreational drugs? Yes No If yes, how often?

Hearing:
Check all that apply:
- No difficulties
- Tinnitus/ringing in the ears
- Sensitivity to noise
- Decreased hearing acuity
- Decreased auditory processing
- Do you wear hearing aids? Yes No
- Do you wear them consistently? Yes No
- Do they help you? Yes No
Vision
Check all that apply:
- No difficulties
- Glasses for reading
- Glasses for vision
- Contact lenses
- No difficulties
- Blurry vision
- Sensitivity to light
- Double vision
- Decreased peripheral vision
- Headaches with reading
- Decreased tracking abilities

Do you have any difficulties with driving? If yes, please explain.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________