**SPEECH THERAPY EVALUATION**

**Name of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**­­­\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_**

**Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(circle one) PT OT ST Visit Length:

An evaluation of this \_\_\_\_\_\_ year-old was requested by:

to assess:

**Diagnoses** known at this time include:

**Other factors impacting function** include:

**Prior Level of function**:

Currently living in with:

**Current Functional Status**:

Swallow

Cognition

Motor Speech

Dysphagia

Language

Read / Write

Ears / Eyes

Sensory/ pain

Socialization

Finances

**Treatment provided today**:

**Assessment:**

**Problem List:**

**Recommendations:**

**Plan:** Frequency, Duration

**SHORT TERM GOALS:**

**LONG TERM GOAL:**

Therapist Signature: Date