VOICES OF HOPE FOR APHASIA
www.vohaphasia.org

| Date: |
|---|

| Name: | Date of Birth: |
|---|---|
| Caregiver Name: | |
| *Mailing address* | |
| Address: | |
| City/State/Zip: | |
| Phone: | Email: |
| *Residential Address (if different than above)* | |
| Address: | |
| City/State/Zip: | |

***In case of emergency, please contact:***

| Name: | Relationship: |
|---|---|
| Phone: | Alternate Phone: |
| Email: | |

***Medical Information:***

**Cause of Aphasia *(Please check all that apply)*:**
□ Stroke: Date(s) _____
□ Brain Injury: Type & date(s) _____
□ Other: Date(s) _____
□ Aphasia Type (i.e. expressive, receptive, Primary Progressive)_____

**Allergies:** ***(Please list/describe any that apply. Include food allergies, drug allergies, latex, etc.)***

**Other Medical Conditions:**

| In case of emergency, do you have preferred hospital? | |
|---|---|

***Check the following according to your/person with aphasia's present abilities (i.e., what you can do):***

**Auditory Comprehension/Listening**
___ Follows requests & understand directions
___ Follows radio or television speech
___ Repeats words spoken by others

**Reading**
___ Reads/understands □ words □ numbers
___ Reads newspapers, magazines
___ Reads & follow directions

**Speaking**
___ Uses some words spontaneously
___ Uses one or a few words over and over
___ Says short phrases or sentences
___ Participates in conversation? □ Yes □ No

**Writing**
___ Writes name without assistance
___ Writes □ letters, □ numbers, □ sentences

**How did you hear about Voices of Hope for Aphasia? _____**

***Please use back of sheet to provide additional information we may find helpful.***