

Adult Intake Form / History

Client Name: _____ Today's Date _____
Nickname: _____

Date of Birth: _____ Age: ___ Male Female Prefer Not To Respond

Diagnosis (if known): _____

Address: _____

City, State, Zip: _____

Phone #1: _____ Cell Home Work Other

Phone #2: _____ Cell Home Work Other

Email #1: _____ Email #2: _____

Marital Status: Single Married Widowed Divorced

If under 18, name of parent/guardian: _____

Name of Spouse or Closest Relative: _____

Permission to Contact: Yes No

Contact Information: _____

Others Living In the Home: _____

Are you receiving any assistance in the home? Yes No

Describe: _____

Language(s) Spoken: _____

Are you currently driving? Yes No

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

Occupation: _____ Employed Retired Unemployed

How did you hear about us?

Current Status

Please describe your present concern:

Is your communication difficulty related to your work? Yes No

Is your communication difficulty related to an accident? Yes No

Date of occurrence: _____

Describe: _____

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: _____

What do you think caused your speech problem? _____

What are you expecting out of this evaluation / meeting? _____

Have you ever had a previous speech, language or feeding evaluation / treatment? Yes No By whom: _____ When: _____

Describe the results: _____

Are you currently working with another provider? Yes No

Provider Name: _____

Contact Information: _____

Location: _____

Has the problem improved or gotten worse? Describe: _____

When did you first notice the problem? _____

How does your communication difficulties impact your life, social, work, hobbies, etc.? _____

What strategies do you use to help cope with this problem? _____

Does anyone in your family have a history of the same (or different) communication difficulty? _____

Background & History

Describe any pertinent information regarding your medical history (birth injuries, abnormalities, surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

Describe your current health status: _____

Have you ever had surgery for a related issue? Yes No
Please describe: _____

Have you ever been hospitalized for a related issue? Yes No
Please describe: _____

Have you ever been in a serious accident? Yes No
Please describe: _____

Do you have a chronic illness? If so, please describe: _____

Are you currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Do you have any physical disabilities? _____

Do you currently use any equipment? (Communication device, walker, etc.)
Describe: _____

Check and describe all that apply:

- Allergies Describe: _____
- Asthma Describe: _____
- Attention Deficit Disorder Describe: _____

- Auto accident Describe: _____
- Brain injury Describe: _____
- Breathing problems Describe: _____
- Cancer Describe: _____
- Cardiac issues Describe: _____
- Cleft palate Describe: _____
- Cognitive concerns Describe: _____
- Degenerative illness Describe: _____
- Depression Describe: _____
- Developmental delay Describe: _____
- Diabetes Describe: _____
- Ear infections Describe: _____
- Encephalitis Describe: _____
- G-tube Describe: _____
- Hearing loss Describe: _____
- Pneumonia Describe: _____
- Psychiatric concerns Describe: _____
- Respiratory problems Describe: _____
- Seizures Describe: _____
- Stroke / TIA Describe: _____
- Swallowing problems Describe: _____
- Other Describe: _____

Have you ever been evaluated by the following specialties? Check all that apply

- Audiologist
- Gastroenterologist
- Occupational Therapist
- Otolaryngologist
- Physical Therapist
- Psychologist

Psychiatrist

Speech Therapist

If yes, please describe the nature of the evaluation and any results: _____

Highest grade completed: _____ Degree earned: _____

Name of Institution(s): _____

Please upload copies of any previous evaluations or progress reports. You may also bring them in at our first meeting.

During school, did you have any problems with the following? Check all that apply:

Learning Understanding Memory Behavior Attention

Reading Speaking Writing Problem Solving

Describe: _____

What are your responsibilities in the home? Check all that apply:

Cooking Cleaning Child care Driving Finances

Laundry Repairs Shopping Yard work

Are there any questions you would like us to answer for you? _____

Is there anything else that is important for us to know about you?

Person filling out the form: _____

Relationship to the client: _____