Connections
speech and language therapy

info@connectionsspeechtherapy.com
www.connectionsspeechtherapy.com
Berea KY, 40403
(859) 626-2271

Client History Intake Form

Please read each item and make all answers as completely as possible

Do you need assistance filling in this form? Check: [ ] YES [ ] NO

Identifying Information:

Client Name: _____ Sex: ____ DOB: _____

Street Address: _____

Apt./Suite: _____ City: _____ State: KY Zip: _____

Phone (check preferred):

[ ] Home: _____ [ ] Cell: _____ [ ] Work: _____

Email: _____

Primary Language: _____ Secondary Language(s): _____

Emergency Contact:

Name: _____ Phone: _____

Relationship to client: Circle: CAREGIVER SPOUSE LEGAL REPRESENTATIVE OTHER

If other, please specify: _____

Referring physician (if applicable):

Name: _____ Phone: _____

Existing speech or language diagnosis, if known:

Check: [ ] Dysarthria [ ] Apraxia [ ] Aphasia [ ] Dysphagia (trouble swallowing)

[ ] Stuttering [ ] Unknown [ ] Other (specify): _____

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Have you received speech/language therapy in the past? Check: [ ] YES [ ] NO

If yes, please describe:

_____

_____

Facility/location: _____ Phone: _____

Provider name: _____

Please describe, as completely as possible, the concern you have regarding your communication/swallowing abilities: _____

_____

_____

_____

When did you first notice a problem?

_____

Has your condition improved, remained unchanged, or become worse? Please explain:

_____

_____

Were there any special circumstances around the start of your symptoms? Please explain:

_____

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List any current medications & dosage (if applicable):

What was your main reason for requesting this appointment?

How would you rate the severity of the problem now?

Use the following rating scale:

1 2 3 4 5 6 7 8 9 10

MILD
Symptoms have little to slight impact on my daily routines or quality of life and do not prevent me from doing activities

MODERATE
Symptoms have a noticeable impact on my daily routines or quality of life and prevent me from doing some activities

SEVERE
Symptoms negatively impact my daily routines or quality of life and prevent me from doing many, or most activities

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Check any of the following that currently describes your communicative abilities:

[ ] difficult to understand because of my speech

[ ] difficulty initiating a conversation

[ ] have difficulty organizing thoughts

[ ] stutter

[ ] difficulty concentrating

[ ] dialect is difficult for others to understand

[ ] voice is hoarse, breathy

[ ] trouble chewing and/or swallowing

[ ] difficulty with word-finding

[ ] difficulty reading / writing

Please describe any other concerns:

_____

Do you have any difficulty with your hearing?

Check: [ ] YES [ ] NO

If yes, please explain: _____

What do you hope to learn from an evaluation/ What do you think should be done?

_____

_____

_____

Do you currently, or have you ever, experienced any pain associated with this problem?

Check: [ ] YES [ ] NO

If yes, please explain: _____

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Personal & Medical History

The following information is important for diagnosis and treatment. Please answer to the best of your knowledge.

Prenatal and Birth History

Check: [ ] Full term [ ] Normal Birth

Explain any complication related to prenatal events/delivery: _____

_____

Development:

Your general impression of your overall speech/language development:

Check: [ ] Slow [ ] Normal [ ] Advanced

Comments: _____

Your general impression of your early motor development:

Check: [ ] Slow [ ] Normal [ ] Advanced

Comments: _____

Has anyone on either side of your family ever had a communication problem, been slow in talking, had trouble being understood or experienced any voice difficulties? (Please explain): _____

_____

Medical History:

Please list any medical conditions/illnesses (past and present): _____

_____

_____

_____

Allergies: _____

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Are you allergic to latex? Check: [ ] YES [ ] NO

List any recent hospitalizations, what for & dates: _____

_____

_____

Are you currently under a doctor's care? If yes, what reason? _____

_____

Do you have any eating or swallowing difficulties/PEG tube? If yes, describe: _____

_____

Have you had a modified barium swallow study or Fiberoptic Endoscopic Evaluation? If yes, when and by whom? (dates): _____

_____

Are you on a special diet or diabetic diet? (Thickened liquids, pureed foods, etc.): _____

_____

Describe any major surgeries, operations, or hospitalizations (include dates): _____

_____

Educational History:

Circle highest grade completed:

High school: 1 2 3 4 5 6 7 8 9 10 11 12 University: 1 2 3 4 Graduate: 1 2 3 4

List any area of specialization, vocational training, or area of university study: _____

_____

Describe any other education or special training: _____

Do you have a history of learning difficulties? If yes, please explain: _____

_____

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Employment History:

Most recent occupation: _____ How long? _____

Employer: _____ Are you still employed? Check: [ ] YES [ ] NO

What are your current employment arrangements? _____

_____

Describe briefly the type of work you are/were doing in current/past occupations: _____

_____

Please give any additional information that will help us in the evaluation: _____

_____

_____

_____

_____	_____	_____
Signature of person completing this form	Relationship to client (if applicable)	Date