ADVANCED
THERAPY SOLUTIONS

120 N Perkins Road Suite F Stillwater, OK 74075❖405.564.2701❖www.ats-stillwater.com

Adult Intake Form

Name of person completing this form: _____

Relationship to patient: _____**Phone:** _____

Patient's Name:	SS#:
Address:	Date of Birth:
City, State, Zip:	Home Phone:
Employer:	Work Phone:
E-mail Address:	Cell Phone:

Primary Language:_____

Physician:_____**Phone:**_____

Marital Status: (Please circle) ***Single*** ***Married*** ***Divorced*** ***Widowed***

Spouse's Name:	SS#:
Address, if not the same:	Date of Birth:
City, State, Zip:	Home Phone:
Employer:	Work Phone:
E-mail Address:	Cell Phone:

Others living in the home:_____

Emergency Contact: _____ **Phone:**_____

- **Relationship to patient:** _____

Insurance:

Primary Insurance	
Insurance Carrier:	Contract/ID Number:
Name on Card:	Group Number:
Date of Birth:	SS# of Primary Insured:

Secondary Insurance	
Insurance Carrier:	Contract/ID Number:
Name on Card:	Group Number:
Date of Birth:	SS# of Primary Insured:

Please check the appropriate box below:
I, the undersigned, ☐certify ☐do NOT certify that I (or my dependent) have insurance coverage with the entity(s) listed above and assign directly to **Advanced Therapy Solutions, LLC** all benefits from the above entity, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Advanced Therapy Solutions, LLC** to release all information necessary to secure the payment of benefits.

Please circle if you have a history of any of the following:

Allergies	***Chronic Colds***
Pneumonia	***Cleft Palate***
Stroke/TIA	***Problems Swallowing***
Head Injury Date:_____	***Auto Accident Date: _____***
COPD/Emphysema	***Chronic Cough***
PEG Tube	***Cancer***
Respiratory Problems	***Ear Infections***
Developmental Delay	***Degenerative Disease***
Cognitive Impairment	***Chemotherapy***
Acid Reflux	***Radiation***
Other (Please Specify):	

Please list any allergies (medication, food, products, etc):
_____
_____

Please describe any birth injury or diagnosed abnormality:_____
_____

Have you ever been referred to any of the following specialists? (Please circle)

Audiologist	Psychologist
Physical Therapist	Otolaryngologist (ENT)
Psychiatrist	Speech therapist
Gastroenterologist	Occupational therapist
Neurologist	Other:_____

If yes, please state the reason and the results:_____
_____
_____

Test(s) completed: (Please circle)
Modified Barium Swallow Study **FEES** ***MRI*** ***CT scan***
Chest x-ray ***Other:_____***

Have there been any recent hospitalizations? ***Yes No*** If yes, please describe with dates:
_____
_____

Please list the medications you are presently taking (prescription and non-prescription):_____
_____
_____
_____
_____

Please circle your answer.
Do you smoke? ***Yes No*** If yes, how much per day?_____
Do you have a history of smoking? ***Yes No*** If yes, for how long? _____
Do you drink alcohol? ***Yes No*** If yes, how much?_____
Do you currently drive? ***Yes No***

Educational History:
Highest grade completed: _____ Degree(s): _____
Name of institution/school: _____
Have you ever had difficulty with any of the following during educational years? (Circle)
Understanding Reading Speaking Writing Attention Memory Problem solving

Work History:
Currently employed? ***Yes No*** Occupation: _____
Job duties:_____
How does your communication impairment impact you ability to work?
_____
_____

Social History:
Employment/work/school:
Full time Part time Retired Student Unemployed

Hobbies/Interests/Sports:_____
_____

What are your household responsibilities? (Circle all that apply)

Computer Tasks	**Balancing Checkbook**
Grocery Shopping	**Cooking**
Cleaning	**Child Care**
Household Repairs	**Yard Work**
Laundry	**Pet Care**
Driving	**Medication Management**

Therapy History:
List any therapy you have received (include when, where, and duration):_____
_____

What information do you hope to obtain from this evaluation?_____
_____

Is there any other important information that you feel may be helpful to your evaluation or treatment?_____
_____

Please list any questions you would like answered:_____
_____
_____

What is your primary goal for participation in Speech-Language Pathology Services?_____
_____
_____

Who referred you to Advanced Therapy Solutions, LLC for Speech-Language Pathology Services? How did you hear about us?_____
_____

Who will be responsible for payment of speech therapy services? _____

Would you like to receive a courtesy reminder for every scheduled appointment? (circle)

Yes *or* ***No***

-If yes, would you like to receive an e-mail or call reminder? ***E-mail*** ***Text*** ***Call***

Please provide the e-mail address or phone number where you would like to receive reminders: _____

Thank you for taking the time to complete this information!

_____
Signature of Patient or Responsible Party

_____
Date