Adult Intake Form

Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

City, State, Zip: _____

Employer: _____**Business Phone:** _____

Email: _____**Referred by:** _____

Family Physician: _____**Physician Phone:** _____

Physician Address: _____

Are you: ☐ **Single** ☐ **Windowed** ☐ **Divorced** ☐ **Married - Spouse's Name:** _____

Children: (include their name, gender and age)

_____

_____

Who lives in the home?

_____

_____

What language(s) do you speak? Which is your dominant language? _____

_____

What was the highest grade, diploma or degree you earned?

_____

GENERAL INFORMATION

Describe your speech-language problem.

_____

_____

_____

What do you think may have caused the problem?

_____

_____

_____

Has the problem changed since it was first noticed? How? ☐ Yes ☐ No

_____

_____

_____

Have you seen any other speech-language specialists? ☐ Yes ☐ No

If Yes, When and for how long? _____

What were their conclusions or suggestions?

_____

_____

_____

Have you received any speech therapy while homebound? ☐ Yes ☐ No

Have you seen any other specialists?
(physicians, audiologists, psychologists, neurologists, etc.)? ☐ Yes ☐ No

If yes, indicate the type of specialist, when you were seen and the specialist's conclusions or suggestions.

_____

_____

_____

Are there any other speech, language or hearing problems in your family? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

MEDICAL HISTORY

Provide the approximate ages at which YOU suffered the following illnesses and/or conditions:

Allergies	**Asthma**	**Colds**
Dizziness	**Draining Ear**	**Ear Infections**
Encephalitis	**Headaches**	**Hearing Loss**
High Fever	**Influenza**	**Mastoiditis**
Meningitis	**Noise Exposure**	**Otosclerosis**
Pneumonia	**Seizures**	**Sinusitis**
Tinnitus	**Other**	

Have you had a modified Barium Swallow Study? ☐ **Yes** ☐ **No**

Do you have any eating or swallowing difficulties? ☐ **Yes** ☐ **No** **If yes, please describe:**

_____

_____

_____

_____

List all medications you are taking.

_____

_____

_____

_____

Are you having any negative reactions to these medications? ☐ **Yes** ☐ **No**

Describe any major surgeries, operations or hospitalizations and when they occurred.

_____

_____

_____

_____

Describe any major accidents and when they occurred.

_____

_____

_____

_____

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation process.

_____

_____

_____

_____

_____

_____

_____

(Please feel free to use the back for additional space)

Person completing form: _____

Relationship to patient: _____

Signature: _____

Date: _____

Please return this packet of information by mail prior to the evaluation, if possible, so the therapists can review and prepare the necessary evaluation. If it is not possible to return these prior to the evaluation, please bring them with you on the day of the evaluation.