



## 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  Widowed  Divorced  Married - Spouse's Name: \_\_\_\_\_

Children: (include their name, gender and age)

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Who lives in the home?

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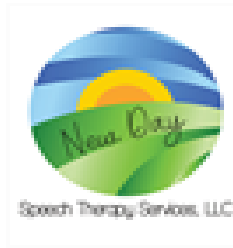
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What language(s) do you speak? Which is your dominant language? \_\_\_\_\_

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

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**GENERAL INFORMATION**

**Describe your speech-language problem.**

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**What do you think may have caused the problem?**

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

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

**If Yes, When and for how long? \_\_\_\_\_**

**What were their conclusions or suggestions?**

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**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.**

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

**If yes, please describe:**

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**MEDICAL HISTORY**

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

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



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

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

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**List all medications you are taking.**

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

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

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**Describe any major accidents and when they occurred.**

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**ADDITIONAL INFORMATION**

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

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**(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.**