CONNECT
speech language & swallowing services

ADULT SPEECH-LANGUAGE PATHOLOGY INTAKE FORM

Date:	Age:

I. Client Information

Name: _____ Gender: _____ DOB:_____
Phone number (s):_____
Mailing address: _____
Email:_____
Other:_____
Emergency contact:_____
Family physician name, phone, address:_____
_____
Person filling out form (if not client): _____ Relationship:_____

II. Reason for Referral

Briefly describe in your own words your reason for referral:
_____
_____

III. Educational History

Highest grade completed:_____ Degree(s):_____
Name of institution/school:_____
Have you ever had difficulty with any of the following during educational years? (Please circle.)
understanding reading speaking writing attention memory problem solving
Currently in school? *full-time part-time other*:_____
If yes, what program/area of study, where and what level/year?
_____

IV. Work History

Please circle: *Student Unemployed Part-time Full-time Casual Retired Long-term Disability*
Current Employer: _____
Duration of employment: _____
Occupation: _____
Job duties:_____

V. Social History

What languages do you speak fluently? If more than one, which one is your primary language?

_____

Who lives with you? _____

Marital status of client: _____ Spouse: _____

If married/common law, indicate duration:_____

Children: _____

Interests: _____

Leisure activities:_____

Volunteer/avocational pursuits: _____

Sports/hobbies:_____

Are you currently driving? *Yes* *No* If no, please explain: _____

What are your typical daily responsibilities? (Circle all that apply.)

computer tasks
household finances
grocery shopping
cooking
cleaning
child care
household repairs
yard work
laundry
driving
Other:
_____

VI. Health History

1. 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?_____

2. Please circle if you have been diagnosed with any of the following:

- ○ chronic colds
- ○ asthma
- ○ pneumonia
- ○ chronic cough
- ○ ear infections
- ○ hearing loss
- ○ vision issues
- ○ cleft palate
- ○ PEG Tube
- ○ developmental delay
- ○ depression/ mental illness
- ○ stroke/TIA
- ○ cancer
- ○ degenerative disease
- ○ seizures/ epilepsy
- ○ problems swallowing
- ○ respiratory problems
- ○ A.D.D.
- ○ known allergies
- ○ drug sensitivities
- ○ auto collision date:_____
- ○ head injury date:_____
- ○ cognitive impairment: _____
- ○ birth injury or diagnosed abnormality: _____
- ○ other: _____

If you have known allergies, please describe: _____

If you have known drug sensitivities, please describe: _____

If you have seizures, please describe how often?_____

If you have known hearing loss, do you wear hearing aids or have you had any intervention for your hearing? _____

If you have known vision problems, please describe: _____

Do you wear glasses or contact lenses? _____

3. List 1) major illnesses, diseases, operations or accidents; 2) age at the time of each; and 3) resulting health/functional changes.

Illnesses/diseases/operations/accidents *Age* *Impact on health/function*

_____
_____
_____
_____

Were you hospitalized for any of the above conditions? _____ If so, where and for how long?

_____

4. Have you ever been referred to any of the following specialists?

- audiologist
- otolaryngologist (ENT)
- gastroenterologist
- psychologist
- psychiatrist
- occupational therapist
- physical therapist
- speech-language pathologist/speech therapist
- Other: _____

If yes, please state the reason and the results of any assessment:

_____
_____
_____

5. Diagnostic Test(s) completed:

- Chest x-ray
- Arterial Studies
- MRI
- Audiogram
- Tissue Biopsy
- Bone Scan
- Venous Doppler
- CT Scan
- Wound Cultures
- EMG
- X-Rays
- ENG
- Other:_____

Results:_____
_____

6. Please list the medications you are presently taking (prescription and non-prescription):
What? For what? How much? How often?

_____
_____
_____

7. Are you currently under the care of a specialist? _____ If yes, for what?_____

_____

8. Any other relevant health/medical information you feel is relevant to share?

_____
_____

VII. History of Presenting Concern

1. How severe is the diagnosis of your current problem/concern? *unsure* *mild* *moderate* *severe*

C: 519-852-9771 **F: 1-800-599-8001** **www.connectspeech.ca** **info@connectspeech.ca**

How severe do you perceive your problem/concern is now? *unsure* *mild* *moderate* *severe*

Please describe in detail the present problem/concern affecting your speech, language, cognitive-communication, hearing and/or swallowing:

_____

_____

_____

2. What areas of your life is it affecting? *work* *school* *social* *family* *daily life* *leisure/hobbies*
Other: _____

3. Does anyone in your immediate or extended family experience similar problems/concerns? _____
If yes, describe: _____

_____

4. Do you know what caused your problem/concern to occur? _____ Please describe:

_____

_____

5. When/what age did it begin?

_____

6. Did the problem/concern have a gradual onset or a sudden onset? Describe:

_____

7. Has the problem/concern changed since you first noticed it? _____ If yes, describe:

_____

8. How often does the problem/concern occur?

_____

9. Do you others notice/comment on your problem/concern? _____ If yes, describe:

_____

10. Are there times/situations when your problem/concern is better or worse? _____ If yes, describe:

_____

_____

11. What is your primary means of communication?_____

12. Are you understood when you speak? _____ If not, describe:

_____

13. Do you avoid speaking situations? _____ If yes, describe:

_____

14. In general, how do you feel about your present problem/concern overall?

_____

IIX. Therapy History

1. Have you been assessed/diagnosed by a Speech-Language Pathologist for the problem/concern? _____ When? _____
Severity at that time? *unknown mild moderate severe*

2. Have you previously had speech-language therapy for your present problem/concern? _____ If yes, please describe for what, when, where, with whom and duration and why therapy was discontinued:
_____
_____

3. Have you received any other speech-language therapy in your lifetime? _____ If yes, please describe:
_____
_____

4. What do you hope to obtain from an assessment, if one is required?
_____

5. If therapy is indicated, what do you hope to improve or gain through speech-language therapy?
_____
_____

6. What other information can you provide which will enable *Connect* to better understand who you are (personality, what motivates you, etc)?
_____
_____

7. Is there any additional information you think would be helpful to share?:
_____
_____

8. Please list any other questions you would like answered during the consult/assessment:
_____
_____

IX. Referral Information

How did you hear about *Connect Speech Language & Swallowing Services*?

- ○ Internet search
- ○ OSLA (Ontario Association of Speech-Language Pathologists & Audiologists)
- ○ CASLPO (College of Audiologists & Speech-Language Pathologists of Ontario)
- ○ SAC (Speech-Language & Audiology Canada)
- ○ Yellow Pages/ Print Directory
- ○ Word of Mouth
- ○ Advertisement
- ○ Presentation
- ○ Newspaper publication
- ○ Other_____
- ○ Direct referral (Name, Address, Agency, Phone, if applicable):
  _____