CONNECT
speech language & swallowing services

ADULT NEUROLOGY SPEECH-LANGUAGE PATHOLOGY INTAKE FORM

Date of completion:	**Age:**

I. Client Information

Name: _____Gender: _____ DOB: _____
Phone number(s): _____
Mailing address: _____
If long-term care) date admitted:_____
Email: _____
Other:_____
Emergency contact: _____
Family physician name, phone, address: _____
_____
Person completing form (if not client): _____
Relation:_____

II. Referral Information

1. Briefly describe in your own words your reason for seeking speech-language pathology services: _____

2. How did you find out about *Connect Speech*?
_____

III. Education History

Highest level completed: _____
Area(s) of study: _____
Name of institution/school: _____

IV. Employment History

Employment status: *full-time part-time casual retired* _____
What was your primary/previous occupation _____

V. Social History

1. General history:

What languages do you speak fluently? If more than one, please indicate your native language. _____
Handedness before injury/health issue: *R* *L* After injury/health issue: *R* *L*
Who currently lives with you? _____
Marital status: _____ Spouse: _____ Duration: _____
Children: _____
Primary support system: _____
Interests: _____
Leisure activities: _____
Volunteer pursuits: _____
Sports/hobbies:_____
Are you currently driving? _____ If no, please explain: _____

2. Describe if any of the following have happened in the past year:

Death of spouse _____
Death of other close family member or friend _____
Change in health of family member _____
Change in living situation _____
Divorce or separated, marriage or "pairing up" _____
Change in financial status _____

3. What are your regular responsibilities?

a) self-care
b) computer tasks
c) household finances
d) grocery shopping
e) cooking
f) cleaning
g) child care/grand children
h) household repairs
i) yard work
j) laundry
k) driving
l) Other: _____

If you are not able to do any of the above independently, please indicate the lettered item and if minimum (-) or maximum support (+) is needed:

_____

VI. General Health History

1. Is your general health: Excellent ___ Average ___ Poor ___
If 'Poor' please explain:

_____

2. Please indicate your answer.
Do you smoke? _____ If yes, how much per day?_____
Do you have a history of smoking? _____ If yes, for how long? _____
Do you drink alcohol? _____ If yes, how much? _____

3. Describe any known allergies or drug sensitivities:
_____

4. Have you been prescribed hearing aids or glasses/contact lenses?
_____

5. Major health issues: illness, injuries or operations?

Health issue	Age	Hospitalized? (duration)	Resulting handicap(s)?

6. Diagnostic test(s) completed for above major health issues:
- ○ Chest x-ray
- ○ MRI
- ○ Audiogram
- ○ CT/CAT Scan
- ○ EMG
- ○ X-Rays
- ○ Other:_____

Approximate Dates/Results:
_____
_____

7. Please list the medications you are presently taking (prescription and non-prescription/supplement). Include drug name, targeted condition, dosage:
_____
_____
_____

8. Are you currently under the care of a specialist physician? _____ If yes, please state reason(s). _____
_____

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VII. History of Presenting Concern

1. Injury Details

Date of injury: _____ Cause of injury (accident, stroke, disease):_____
Length of unconsciousness (if any): _____
Describe paralysis (if any): _____
Any complaints of: Dizziness: Yes No Faintness: Yes No Headaches: Yes No
Handedness before injury: Right Left Handedness after injury: Right Left
Do you experience any new vision and/or hearing problems as a result of the present condition? _____ If yes, please explain:

_____
_____

Please describe any other medical background information related to this specific concern:

_____
_____
_____

2. Communication History

a. What was the speech, language, and/or cognitive-communication functioning like at the onset of the problem?

_____
_____

b. Please describe in detail the present concerns about cognitive-communication functioning:

_____
_____
_____
_____

c. How severe do you perceive the problem/concern is today?
unsure mild moderate severe

d. Are there times/situations when the problem/concern seems better or worse?
_____ . If yes, describe: _____
_____

e. How do you (the client) feel about your present problem/concern overall?

_____

f. Has there been any previous speech and language assessment for this communication concern? _____
When? _____ Where? _____
By whom? _____
Diagnosis/severity:_____
Please attach or have sent copies of any relevant reports from other agencies.

g. Check the following according to present abilities (i.e., what you can do):

- ○ Indicate meaning by gesture
- ○ Say short sentences
- ○ Repeat words spoken by others
- ○ Tell time
- ○ Follow requests & understand directions
- ○ Write name without assistance
- ○ Use one or a few words over and over
- ○ Follow radio or television speech
- ○ Write sentences, letters
- ○ Use some words spontaneously
- ○ Read signs with understanding
- ○ Do simple arithmetic
- ○ Say short phrases
- ○ Read newspapers, magazines
- ○ Handle money, make change
- ○ Participate in conversations

h. What strategies/tools are relatives/friends using to help with the communication difficulty?

_____
_____
_____

i. Has this communication difficulty affected other areas of life? Yes No If yes, explain (Example: family, hobbies/leisure pursuits, social, work, school, group activities such as church):

_____
_____

j. Since the injury, describe any changes in mood, personality, ability to care for self, etc.:

_____

VIII. Other

a. Is there any other information you can provide to better understand you, the client? (personality, what motivates you, etc)

_____
_____

b. Do you have any specific questions that you would like to have answered?

_____

_____

c. If therapy is indicated, what do you hope to achieve or gain by attending speech-language therapy?

_____

_____

Date:_____

Client Signature:_____

Spouse/substitute decision maker:_____

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