CONNECT
speech language & swallowing services

SPEECH-LANGUAGE PATHOLOGY INTAKE FORM
ADULT & OLDER ADULT

Date of completion:	Age:

I. Client Information

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

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 _____
Approximate years worked: _____

V. Social History

1. General:
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:

_____

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VI. General Health History

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

_____

2. Please circle 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
- ○ CT/CAT Scan
- ○ Other:_____
- ○ MRI
- ○ EMG
- ○ Audiogram
- ○ X-Rays

Approximate Date/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). _____

_____

VII. Presenting Concern

1. Primary present concern/diagnosis: _____
2. When and by whom was diagnosis completed? _____
3. Do you experience any new vision and/or hearing problems as a result of the present concern? _____ If yes, please explain: _____

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

5. Was the onset of related speech, language and/or cognitive-communication changes gradual or sudden? _____

6. What were the primary speech, language, communication and/or cognitive-difficulties (memory, attention etc.) at the onset of the problem?

_____

_____

7. How have the difficulties progressed/changed over time?

_____

_____

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

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

_____

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

_____

11. Has there been any speech and language intervention? _____
What? _____

By whom? _____
Diagnosis/severity:_____
Please attach or send copies of any relevant reports.

12. Has the presenting difficulty significantly affected any of the following:

- Daily conversations
- Social life/friendships
- Family interactions
- Work/volunteering
- Daily life activities (e.g. banking)
- Hobbies/leisure pursuits
- Community Outings
- Other:_____
- Group activities (e.g. games, place of worship)

13. Describe any changes in sleep, mood, personality, or behaviour as a result of present concern/diagnosis:

_____

_____

14. What do you hope to obtain from an assessment, if required?

_____

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

_____

_____

16. Is there any additional information you think would be helpful for the assessment or therapy?:

_____

_____

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

_____

_____

18. Please list any other questions you would like answered during the assessment:

_____

_____

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