Adult Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Diagnosis (if known): _____

Address: _____

City, State, Zip: _____

Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email #1:_____ Email #2: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If under 18, name of parent/guardian: _____

Name of Spouse or Closest Relative: _____

Permission to Contact: ☐ Yes ☐ No

Contact Information: _____

Others Living In the Home: _____

_____

Are you receiving any assistance in the home? ☐ Yes ☐ No

Describe: _____

Language(s) Spoken: _____

Are you currently driving? ☐ Yes ☐ No

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

Occupation: _____☐ Employed ☐ Retired ☐ Unemployed

How did you hear about us?

_____

<u>Current Status</u>
Please describe your present issue: _____
_____
_____
_____

Is your communication difficulty related to your work?   ☐Yes   ☐No
Is your communication difficulty related to an accident? ☐Yes   ☐No
Date of occurrence: _____
Describe: _____
_____
_____

Briefly describe why you're seeking an evaluation by a speech-language
pathologist at this time: _____
_____
_____
_____

What do you think caused your speech problem? _____
_____
_____
_____

What are you expecting out of this evaluation / meeting? _____
_____
_____

Have you ever had a previous speech, language or feeding evaluation /
treatment?   ☐Yes ☐No   By whom: _____When: _____
Describe the results: _____
_____
_____

Are you currently working with another provider? ☐Yes ☐No
Provider Name: _____
Contact Information: _____

Location: _____

Has the problem improved or gotten worse? Describe: _____
_____
_____
_____

When did you first notice the problem? _____
_____
_____
_____

How does your communication difficulties impact your life, social, work, hobbies, etc.? _____
_____
_____
_____

What strategies do you use to help cope with this problem? _____
_____
_____
_____
_____

Does anyone in your family have a history of the same (or different) communication difficulty? _____
_____
_____
_____
_____

Background & History
Describe any pertinent information regarding your medical history (birth injuries, abnormalities, surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Describe your current health status: _____

_____

_____

Have you ever had surgery for a related issue? ☐ Yes ☐ No

Please describe: _____

_____

_____

Have you ever been hospitalized for a related issue? ☐ Yes ☐ No

Please describe: _____

_____

_____

Have you ever been in a serious accident? ☐ Yes ☐ No

Please describe: _____

_____

_____

Do you have a chronic illness? If so, please describe: _____

_____

_____

Are you currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Do you have any physical disabilities? _____

_____

_____

_____

Do you currently use any equipment? (communication device, walker, etc.)

Describe: _____

_____

_____

Check and describe all that apply:

☐Allergies   Describe: _____

☐Asthma   Describe: _____

☐Attention Deficit Disorder　　　Describe: _____

☐Auto accident　　　　　Describe: _____

☐Brain injury　　　　　Describe: _____

☐Breathing problems　　　Describe: _____

☐Cancer　　　　　　Describe: _____

☐Cardiac issues　　　　Describe: _____

☐Cleft palate　　　　　Describe: _____

☐Cognitive issues　　　　Describe: _____

☐Degenerative illness　　Describe: _____

☐Depression　　　　　　　　Describe: _____

☐Developmental delay　　　　Describe: _____

☐Diabetes　　　　　　　　　Describe: _____

☐Ear infections　　　　　　　Describe: _____

☐Encephalitis　　　　　　　Describe: _____

☐G-tube　　　　　　　　　Describe: _____

☐Hearing loss　　　　　　　Describe: _____

☐Pneumonia　　　　　　　　Describe: _____

☐Psychiatric issues　　　　　Describe: _____

☐Respiratory problems　　　　Describe: _____

☐Seizures　　　　　　　　　Describe: _____

☐Stroke / TIA　　　　　　　Describe: _____

☐Swallowing problems　　　　Describe: _____

☐Other　　　　　　　　　　Describe: _____

Have you ever been evaluated by the following specialties? Check all that apply

☐Audiologist　　　　　☐Gastroenterologist　　　　☐Occupational Therapist

☐Otolaryngologist　　　☐Physical Therapist　　　　☐Psychologist

☐Psychiatrist　　　　　☐Speech Therapist

If yes, please describe the nature of the evaluation and any results: _____

_____

_____

Highest grade completed: _____　　Degree earned: _____

Name of Institution(s): _____

During school, did you have any problems with the following? Check all that apply:

☐Learning ☐Understanding ☐Memory ☐Behavior ☐Attention
☐Reading ☐Speaking ☐Writing ☐Problem Solving

Describe: _____

_____

_____

What are your responsibilities in the home? Check all that apply:

☐Cooking ☐Cleaning ☐Child care ☐Driving ☐Finances
☐Laundry ☐Repairs ☐Shopping ☐Yard work

Are there any questions you would like us to answer for you? _____

_____

_____

_____

Is there anything else that is important for us to know about you?

_____

_____

_____

_____

_____

_____

Person filling out the form: _____

Relationship to the client: _____