Super Speech Solutions, LLC
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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?
____

Current Status

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: ____