Progressive Therapy Solutions, PLLC
210 E. Creek Street
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Adult Intake Form /History

Today's Date _____
Client Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Pronouns: _____
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: _____
_____
_____

Educational Background: _____
_____

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: _____