Adult Intake Form

Today's Date: __________

Personal Information:

Name: ________________________________ D.O.B: _________ Age: ______

Address: ______________________________ Phone: ___________________ (H)

______________________________ ___________________ (C)

Email: ________________________________

Occupation: ____________________________ Primary Language: ____________

Referring Physician (name and phone #): ____

Reason for Referral: ____

____

Medical History

Please list any/all diagnoses (e.g.: Parkinson's, Alzheimer's, MS): _____________________

____

Current medications: ____

Please report any recent (last 12 months) medical exams or procedures (e.g.: ENT, neurologist, GI):

____

____

History of Reflux?: ________ Unexplained weight loss?: ____________

Allergies: ____

Family history of speech/language difficulties?: ____________________________________

Please check all that apply:

Symptom	Never	Sometimes	Frequently
Difficulty Swallowing			
Dry mouth			
Oral motor difficulties (weakness, incoordination)			
Snoring/restless sleep			
Difficulty with expressing thoughts/ideas/finding words			
Not being understood by others			
Difficulty understanding others/following directions			

Fluency (stuttering)			
Voice changes			
Memory/orientation			
Problem solving			
Other:			

Please explain:

____

____

Impact on daily activities? (Social, work, etc.): _____________________________________

____

Previous evaluation or speech therapy? (where/when): _______________________________

Was it helpful?: ____

Is there family or caregiver support?: ________ If yes, who?: _________________