Broadfield Speech & Swallowing Therapy

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: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____ ☐ Employed ☐ Retired ☐ Unemployed

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: _____

Client's Physician: _____ Phone #: _____

Physician Address: _____

Permission to Contact: ☐ Yes ☐ No

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone #: _____

Physician Address: _____

Permission to Contact: ☐ Yes ☐ No

Are you currently working with another provider (physical/ occupational therapist, social worker)? ☐ Yes ☐ No

Provider Name: _____ Phone #: _____

Permission to Contact: ☐ Yes ☐ No

Current Status

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

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

If not, what do you think may have caused your speech, language or swallowing difficulty? _____
_____
_____
_____

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

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

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

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 in your medical history (birth injuries, abnormalities, surgeries, diagnoses, etc.) as well as when 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 to you:

☐ 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: _____
Area of Degree: _____

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: _____