# & LANGUAGE REHAB SERVIC

## Speech Therapy Intake Form - Adult

**Client Information**

Name: _____ Date: _____ Date of Birth: _____

Nickname/Preferred Name: _____ Gender: _____

How did you hear about our clinic? _____

*Thank you for taking the time to fill out this form as completely and accurately as possible. We value your role in the evaluation process to help us determine the most appropriate treatment. All responses are confidential and will not be released without your permission. Please answer to the best of your knowledge and mark "N/A" for any questions that do not apply.*

**Medical Information**

Primary care physician: _____ Date of last doctor's visit (approx.): _____

Are you currently under the care of any other medical specialists such as a neurologist or audiologist?

If so, please list: _____

Please list any medical diagnoses: _____

Please list any medications you currently take: _____

Please list any allergies: _____

Please describe any history of developmental delays, injuries, or medical complications *(such as stroke, traumatic brain injury, intellectual disability, etc.)*: _____

_____

Is there a family history of speech-language delays or disorders, autism, learning disabilities, or mental health diagnoses? If so, please describe: _____

_____

**Educational/Employment Information**

Do you attend school or a vocational program? If so, please describe: _____

_____

Are you currently employed? If so, please describe: _____

_____

Special services received *(such as speech therapy, occupational therapy, physical therapy)*: _____

_____

Do you experience difficulty participating in school, work, or recreational activities? If so, please describe: _____

_____

**Family/Social information**

Emergency Contact Name: _____ Best contact phone #: _____

Please list who you live with *(such as spouse, roommate, family members, children)*: _____

_____

Do you have difficulty with interpersonal relationships? If so, please describe: _____

_____

Do you need assistance to perform everyday activities such as preparing food, dressing, toileting, getting around? If so, please describe: _____

_____

Which language(s) is/are spoken in the home? _____

Which language(s) do you speak? _____

**Speech/Language/Swallowing**

What is the reason for seeking speech, language, or swallowing services? _____

_____

_____

Which of the following are you currently experiencing? (please mark all that apply):

Difficulty pronouncing words correctly? Yes ☐ No ☐

Stuttering or trouble with speaking smoothly and fluently? Yes ☐ No ☐

Difficulty formulating sentences? Yes ☐ No ☐

Trouble remembering what he/she wants to say? Yes ☐ No ☐

Problems finding the right words to use or mixing up names for things? Yes ☐ No ☐

Difficulty understanding what is said to him/her? Yes ☐ No ☐

Chronic raspy, breathy, or hoarse voice? Yes ☐ No ☐

Difficulty chewing or swallowing? Yes ☐ No ☐

Frequent coughing, choking or gagging when eating and drinking? Yes ☐ No ☐

How long have you been experiencing these problems? _____

Is there anything else you would like us to know about you? _____

_____

_____

*Thank you!*

# CH & LANGUAGE REHAB SERVICES

## Speech Therapy Intake Form - Adult

**Client Information**

Person Completing Form: _____ Relationship to Client: _____ Date: _____

Client's Name: _____ DOB: _____ Gender: _____

How did you hear about our clinic? _____

*Thank you for taking the time to fill out this form as completely and accurately as possible. We value your role in the evaluation process to help us determine the most appropriate treatment. All responses are confidential and will not be released without your permission. Please answer to the best of your knowledge and mark "N/A" for any questions that do not apply.*

**Medical Information**

Client's primary care physician: _____ Date of last doctor's visit (approx.): _____

Is the client currently under the care of any other medical specialists such as a neurologist or audiologist? If so, please list: _____

Please list any medical diagnoses the client has: _____

Please list any medications the client currently takes: _____

Please list any allergies the client has: _____

Please describe any history of developmental delays, injuries, or medical complications *(such as stroke, traumatic brain injury, intellectual disability, etc.)*: _____

_____

Is there a family history of speech-language delays or disorders, autism, learning disabilities, or mental health diagnoses? If so, please describe: _____

_____

**Educational/Employment Information**

Does the client attend school or a vocational program? If so, please describe: _____

_____

Is the client currently employed? If so, please describe: _____

_____

Special services received *(such as speech therapy, occupational therapy, physical therapy)*: _____

_____

Does the client experience difficulty participating in school, work, or recreational activities? If so, please describe: _____

_____

**Family/Social information**

Emergency Contact Name: _____ Best contact phone #: _____

Please list who the client lives with *(such as spouse, roommate, family members, children)*: _____

_____

Does the client have difficulty with interpersonal relationships? If so, please describe: _____

_____

Does the client need assistance to perform everyday activities such as preparing food, dressing, toileting, getting around? If so, please describe: _____

_____

Which language(s) is/are spoken in the home? _____

Which language(s) does the client speak? _____

**Speech/Language/Swallowing**

What is the reason for seeking speech, language, or swallowing services? _____

_____

_____

Which of the following is the client currently experiencing? (please mark all that apply):

Difficulty pronouncing words correctly? Yes ☐ No ☐

Stuttering or trouble with speaking smoothly and fluently? Yes ☐ No ☐

Difficulty formulating sentences? Yes ☐ No ☐

Trouble remembering what he/she wants to say? Yes ☐ No ☐

Problems finding the right words to use or mixing up names for things? Yes ☐ No ☐

Difficulty understanding what is said to him/her? Yes ☐ No ☐

Chronic raspy, breathy, or hoarse voice? Yes ☐ No ☐

Difficulty chewing or swallowing? Yes ☐ No ☐

Frequent coughing, choking or gagging when eating and drinking? Yes ☐ No ☐

How long has the client been experiencing these problems? _____

Is there anything else you would like us to know about the client? _____

_____

_____

*Thank you!*