



& LANGUAGE REHAB SERVICE

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!