

Erika Phillips

SPEECH LANGUAGE PATHOLOGY

Adult Intake Form

Name (First & Last) *

Address *

Address Line 1

Address Line 2

City

Province

Postal Code

Country

Phone *

Date of Birth *

Highest Level of Education

Marital Status

Spouse's Name (if applicable)

Children (Name, Age)

Who Lives In The home?

Languages Spoken

Dominant Language

Describe Your Speech-Language Difficulties

What Do You Hope To Achieve With Speech Therapy?

Have You Seen Any Other Specialists? (Physicians, Occupation Therapist, Physiotherapist, Neurologist, etc.)?

If yes, indicate the name of specialist, when you were seen, and the specialist's conclusions or suggestions.

Speech Language History (Please check all that apply)

- Expressing thoughts
- Understanding what others are saying to you
- Orientation (date, time, year)
- Problem solving
- Reading / Writing
- Maintaining topic of conversation
- Weakness/Difficulty coordinating movements of mouth, cheeks, lips and tongue
- Swallowing/Eating/Drinking
- Clear speech
- Following directions
- Memory
- Focusing / Attention
- Finding the right words to say
- Stuttering
- Voice

Are There Any Other Difficulties Besides What Is Listed Above?

When Was The Problem First Noticed?

Did The Problem Begin Suddenly Or Develop Over Time?

How Or Where Does the Speech-Language Impact You The Most?

Describe Your Daily Communication Needs

Describe Your Interests and Hobbies

Medical History (Please Check All That Apply)

- | | | |
|-----------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart troubles | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic laryngitis |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Head injury | <input type="checkbox"/> Neurological conditions |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Head/neck cancer |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid issues | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Intellectual deficits |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Chronic colds | <input type="checkbox"/> Facial nerve palsy |
| <input type="checkbox"/> Emotional or psychological | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Voice issues or changes | <input type="checkbox"/> Vocal polyps or nodules | <input type="checkbox"/> Other |

What Is Your Current State Of Health?

- Excellent Average Poor

Describe Any Major Surgeries, Operations, Or Hospitalizations (Include Dates)

Please Provide Any Additional Information That You Believe To Be Helpful In The Evaluation or Remediation Process

How Did You Find Me?

Form Completed By

Relationship to Client