Speech Pathways of St. Johns
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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:_____ Email #2: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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: _____

Are you currently driving? ☐Yes ☐No

Client's Physician: _____
Physician Phone Number: _____
Physician Address: _____

Other Physicians / Specialists Involved In Care:
Referring Physician: _____ Phone Number _____
Physician Address: _____
Secondary Physician: _____ Phone Number _____
Physician Address: _____

Occupation: _____☐ Employed ☐ Retired ☐ Unemployed

How did you hear about us?
_____

Current Status
Please describe your present issue: _____
_____
_____
_____

Is your communication difficulty related to your work? ☐Yes ☐No

Is your communication difficulty related to an accident? ☐Yes ☐No

Date of occurrence: _____
Describe: _____
_____
_____

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

What do you think caused your speech problem? _____
_____
_____
_____

What are you expecting out of this evaluation / meeting? _____
_____
_____

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

Are you currently working with another provider? ☐Yes ☐No

Provider Name: _____
Contact Information: _____
Location: _____

Has the problem improved or gotten worse? Describe: _____
_____
_____
_____
When did you first notice the problem? _____
_____
_____
_____

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 regarding your medical history (birth injuries, abnormalities, surgeries, diagnoses, etc.) as well as when they were 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:

☐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: _____
Name of Institution(s): _____

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: _____