Adult Intake Form

Contact/Personal Information

Name: ______ Date: ______
Date of Birth: ______ Age: ______ Sex: Male ☐ Female ☐
Address: ______
City: ______ State: ______ Zip: ______
Home Phone: ______ Cell Phone: ______
Work Phone: ______ Email: ______
Marital Status: ______ Spouse's name: ______
Number & Age of Children: ______ Do you have a conservator? No Yes
Name of conservator: ______

Emergency Contact

Name: ______
Phone Number: ______ Is this number for: home ☐ cell ☐ work ☐
Relationship with Client: ______

Referral Source

Doctor		School		Therapist		Friend		Self		Other	

Name: ______

Reason for Visit Today

______

Have you received speech-language pathology services before? ______ If yes, when? ______
Where? ______
Any other services or treatment received for the current challenge? ______ List here: ______

Medical History

List illnesses, surgeries, injuries, or medical problems: ______

List medications taken on a regular basis: ______

List known allergies and diet restrictions: ______

Please list any diagnoses you have received:	By whom?	When?

Have you had problems with or changes in (check all that apply):

Hearing:					
Wear hearing aid(s)?		No		Yes	If yes, how long?
Had hearing test		No		Yes	If yes, when?
Vision					
Wear glasses?		No		Yes	
Wear corrective lenses?		No		Yes	
Had vision screened?		No		Yes	If yes, when?
Teeth					
Wear dentures?		No		Yes	
Breathing		No		Yes	If yes, describe:
Swallowing		No		Yes	If yes, describe:

Education and Work History

Last grade completed: Degree or diploma earned:

Did you ever receive Special Education Services?

If so, what services?

Occupation:

Occupational goals or interests:

Currently employed or participating in day program?		Yes		No

If yes, where? How many hours per week?

Recreational activities or interests?

Number of approximate hours in front of screen(s) per day:

Additional Information

Is there any else you'd like for us to know about you?

Patient/Parent/Guardian Signature

Relationship to Client

Date