Practice Location: 18266 NW US Highway 441
High Springs, FL 32643
Mailing: PO Box 293
Fort White, FL 32038

Phone: 352-293-8502
Fax: 352-204-9737

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 of 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 **A Sound Approach SLT**?
_____

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 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: _____