Cooper
Therapy Connections PLLC
Speech and Language Pathology
(779) 234-8997

ADULT INTAKE FORM / CLIENT HISTORY

TODAY'S DATE: _____

CLIENT NAME: _____ NICKNAME:_____

DOB: _____AGE: _____ ☐ Male ☐ Female

Home Address: _____ City, State, Zip: _____

Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email #1:_____

Email #2: _____

Diagnosis (if known): _____

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 Occupation: _____ ☐ Employed ☐ Retired ☐ Unemployed

HEALTH

Client's Physician: _____ Phone Number:_____

Physician's Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

<u>Current Status</u>

Please describe your present issue(s):

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? Describe:

Do you currently use any equipment? (communication device, walker, etc.) Describe:

Check and describe all that apply:

☐Allergies

☐Asthma

☐Attention Deficit Disorder

☐Auto accident

☐Brain injury

☐Breathing problems

☐Cancer

☐Cardiac issues

☐Cleft palate

☐Cognitive issues

☐Degenerative illness

☐Depression

☐Developmental delay

☐Diabetes

☐Ear infections

☐Encephalitis

☐G-tube

☐Hearing loss

☐Pneumonia

☐Psychiatric issues

☐Respiratory problems

☐Seizures

☐Stroke / TIA

☐Swallowing problems

☐Other

Describe all that were checked above:

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

OTHER

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?

How did you hear about us? _____

Person filling out the form: _____

Signature:_____ Date:_____

Relationship to the client: _____