ADULT INTAKE FORM

Please answer the following questions about your history. Please attach copies of the following documents:

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations.
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST AT YOUR EARLIEST CONVENIENCE.

YOUR INFORMATION				
Full Name			**Gender**	**DOB**
Current Age		**Profession/Position** **Place of Employment/School**		
Street Address			**City**	**ZIP**
Cell Number		**Is it OK to send you texts?** **YES NO**	**Email Address**	
Primary Care Physician (PCP)	**Name/Address**		**PCP Phone**	
How did you learn about Yardley Speech and Language?				
Emergency Contact	**Name**		**Relation to You**	**Phone**

FAMILY INFORMATION			
With whom do you live?	**Name**	**Relation to You**	**Age**
Has anyone in your family experienced speech/ language/ learning problems?	**Relationship to You**	**Nature of the Difficulty**	

Yardley Speech and Language
103 Eton Rd., Yardley, PA 19067
215-428-2777
www.yardleyspeechandlanguage.com

Your Name: ____________________

SPEECH/LANGUAGE BACKGROUND	
Please describe your speech-language problem.	
Did you experience any communication or learning issues in childhood? Describe.	
Has the problem changed since it was first noticed? How?	
Have you seen any other speech-language pathologists? If yes, when and for how long?	
What were their conclusions or suggestions?	
What do you think may have caused the problem?	
What are your goals for speech-language services?	
Is your family supportive of your decision to seek speech therapy now?	

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Your Name: ____________________

SOCIAL BACKGROUND	
Describe your childhood, including diagnoses, accidents, or communication difficulties.	
Where have you lived?	
Do you speak any other languages? Which ones, and for how long?	
How has your communication problem impacted your work and social life?	
How do you react to your communication difficulties?	
Employment/School Please circle.	Full time Part time Retired Student Unemployed Other ____________
What are your household responsibilities?	Bills/Banking Grocery Shopping Cooking Cleaning Child Care Household/Auto Repairs Yard work Laundry Driving Other: ____________

HEALTH BACKGROUND			
Has your hearing been tested recently?	Date	Provider	Results
Describe any birth injury or diagnosed abnormality.			
Circle and describe any serious illnesses, injuries, or medical procedures you have experienced. Please include approximate dates and durations.	Cardiac Involvement Hypertension Diabetes Nervous System Infection Neurological Disease Seizures Head Injury Previous CVA (Stroke) Reflux Surgery Other	Date/Duration	

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Your Name: ____________________

HEALTH BACKGROUND			
Describe any other conditions or diagnoses you currently have that may not be considered, “serious.”			
List any current medications and their purposes.			
List any environmental or food allergies.			
Describe any difficulties with eating, swallowing, chewing, textured foods, etc.			
Please describe any problems with your teeth, tongue, mouth, ears, nose or throat.			
Describe any vision or hearing problems you may have.			
Have you ever been referred to any of the following specialists? Please circle.	TYPE Otolaryngologist (ENT) Gastroenterologist Psychologist Psychiatrist Occupational Therapist Physical Therapist	PROVIDER	DATE
Please explain reason and results of these specialist consults.			
Have you ever been hospitalized?	Dates	Reason	
Do you smoke?	Yes No	How much per day?	
Do you have a history of smoking?	Yes No	For how long?	
Do you drink alcohol?	Yes No	How many drinks per week?	

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Your Name: ____________________

HEALTH BACKGROUND	
Are you right or left handed?	
Do you have or have you ever had any problems with memory or thinking?	
ADDITIONAL INFORMATION	
Please provide any additional information that might be helpful in the evaluation or remediation process.	

Full name of person completing this form:			
Relationship to Patient			
Signature			**Date**