ALIGN
SPEECH THERAPY AND CONSULTING

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
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 in the home:_____

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

Other Physicians / Specialists Involved In Care:
Referring Physician (if not PCP): _____ Phone Number _____
Physician Address: _____
Secondary Physician: _____ Phone Number _____
Physician Address: _____

Current Status
Briefly describe why you're seeking an evaluation by a speech-language pathologist/reason for referral: _____
_____
_____

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Have you ever had a previous speech, swallowing or voice evaluation/therapy?

☐ Yes ☐ No

By whom: _____When: _____

Describe the results: _____

_____

_____

Are you currently working with another therapy provider (SLP, PT, OT)?

☐ Yes ☐ No

Provider Name: _____

Contact Information: _____

Location: _____

Background & History

Describe any pertinent information regarding your medical history (abnormalities, surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you currently on any medications? If so, please list medication name and reason for medication: (or attach medication list)

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

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

Describe:

_____

_____

Do you wear ☐ Dentures ☐ Eye Glasses ☐ Hearing Aids?

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Do you have any history of the following:

- ☐ Allergies Describe: _____
- ☐ Asthma Describe: _____
- ☐ Brain injury Describe: _____
- ☐ Breathing problems Describe: _____
- ☐ Cancer Describe: _____
- ☐ Cardiac issues Describe: _____
- ☐ Cognitive issues Describe: _____
- ☐ Concussion Describe: _____
- ☐ Degenerative illness Describe: _____
- ☐ Depression Describe: _____
- ☐ Diabetes Describe: _____
- ☐ Feeding tube Describe: _____
- ☐ Hearing loss Describe: _____
- ☐ Hospitalization Describe: _____
- ☐ Memory loss Describe: _____
- ☐ Mental Health issues Describe: _____
- ☐ Pneumonia Describe: _____
- ☐ Prosthesis Describe: _____
- ☐ Psychiatric issues Describe: _____
- ☐ Reflux (GERD,LPR) Describe: _____
- ☐ Respiratory problems Describe: _____
- ☐ Seizures Describe: _____
- ☐ Pneumonia Describe: _____
- ☐ Spine or Back Injury Describe: _____
- ☐ Stroke / TIA Describe: _____
- ☐ Swallowing problems Describe: _____
- ☐ Tobacco Use Describe: _____
- ☐ Weight loss Describe: _____
- ☐ Other Describe: _____

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Have you ever been evaluated by the following specialties? Check all that apply

☐ Audiologist ☐ Gastroenterologist ☐ Occupational Therapist
☐ Otolaryngologist ☐ Physical Therapist ☐ Oncologist
☐ Psychiatrist ☐ Speech Therapist ☐ Neurologist

If yes, please describe the nature of the evaluation and any results: _____
_____
_____

Highest grade completed: _____ Degree earned: _____
Name of Institution(s): _____

What are your responsibilities in the home? Check all that apply:

☐ Cooking ☐ Cleaning ☐ Child care ☐ Driving ☐ Finances
☐ Laundry ☐ Repairs ☐ Shopping ☐ Yard work

Are you currently driving? ☐ Yes ☐ No

Are you currently working? ☐ Employed ☐ Retired ☐ Unemployed
Occupation: _____
Do want to return to work?_____

What are some of your hobbies?_____
_____

What are your personal goals (related to therapy?_____
_____
_____

How did you hear about us?
_____

Person filling out the form: _____
Relationship to the client: _____

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