Pediatric Speech and Occupational Therapy
4700 S Mill Ave #3, Tempe, AZ 85282 | 480-508-7566

Adult Intake Form / History

Today's Date _____

Patient's Name _____ Date of Birth _____
Age _____ □ Male □ Female
Address _____
_____
Phone #1 _____ □Cell □Home □ Work □Other
Phone #2 _____ □Cell □Home □ Work □Other
Email _____
Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed

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 _____
Do you receive any assistance in the home?: □Yes □No
Describe _____

Language(s) Spoken _____

Are you currently driving? □Yes □No

Primary Care Physician _____
Address _____
Phone # _____
Other Physicians / Specialist Involved in Care _____
Referring Physician _____
Address _____ Phone # _____

Occupation _____ □ Employed □ Retired □ Unemployed

Current Status

Please describe your current concern/s:

_____
_____
_____

Is your communication difficulty related to your work? □ Yes □ No
Is your communication difficulty related to an accident? □ Yes □ No
If yes, date of occurrence _____
Please describe _____
_____

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time:

_____
_____
_____

Have you ever had a previous speech, language or feeding evaluation / treatment? □ Yes □ No
By whom _____ When _____
Describe the results _____
_____
If YES, please provide a copy previous evaluations.

Are you currently working with another provider? □ Yes □ No
Provider Name _____ Phone # _____
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.?

_____
_____
_____

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 If so, please describe:

_____

Have you ever been hospitalized for a related issue? □ Yes □ No If so, please describe:

_____

Have you ever been in a serious accident? □ Yes □ No If so, please describe:

_____

Do you have a chronic illness? □ Yes □ No If so, please describe:

_____

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

Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Do you have any physical disabilities: □ Yes □ No If so, please describe:

_____

Do you currently use any equipment? (communication device, walker, etc)? If so, please 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
□ Voice
□ Other

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, describe the nature of the evaluation and any results:

_____
_____
_____

During school, did you have any problems with the following? Check all that apply:
□ Learning □ Understanding □ Memory □ Behavior □ Attention □ Reading □ Speaking
□ Writing □ Problem Solving
If yes, 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 to you?

_____
_____
_____

Is there anything else that is important for us to know about you?

_____

_____

_____

Patient Signature _____ Date _____

If under 18:

Person filling out the form: _____

Signature _____ Date _____

Relationship to the client: _____