

Total Communication Therapy, LLC
Totalcommunicationtherapy@yahoo.com
(770) 954-5655

Adult Intake Form / History

Client Name: _____ Today's Date _____
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 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 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 us?

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 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? _____

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: _____