Speech Therapy Solutions Montana

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Adult Intake Form

Client Full Name: _____ Date of Birth: ___/___/___ Age: ___ Sex: ___

Social Security #: _____ Telephone: Home # / Cell # _____

Home Address: _____

E-Mail: _____ Marital Status: _____

Full Name of Spouse: _____

Employment: _____ Work #: _____

Name of Person Completing This Form (If Client, then disregard): _____

Relation to Client: _____ Telephone: Home # / Cell # _____

Primary Care Physician: _____ Phone #: _____

Others Living in the Home:

_____ Receiving In Home

Assistance? _____ How Often? _____ **WHO MAY WE**

CONTACT IN THE EVENT OF AN EMERGENCY?

Name of Person: _____

Relation to Client: _____ Telephone: Home # / Cell # _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS CLIENT? ☐ Self/Client ☐ Other

Name of Person Responsible: _____

Relation to Client: _____ Telephone: Home # / Cell # _____

Home Address: _____

E-Mail: _____ Marital Status: _____

Employer: _____ Telephone: Work # _____

Employer Address: _____

PRIMARY INSURANCE POLICY ☐ Self/Client ☐ Other Insurance Policy Carrier:

_____ Name of Subscriber:

_____ Relation to Client:

_____

Subscriber ID as shown on the insurance Card: _____

Group ID as shown on the insurance Card: _____

SECONDARY INSURANCE POLICY ☐ Self/Client ☐ Other Insurance Policy Carrier:

_____ Name of Subscriber:

_____ Relation to Client:

_____

Subscriber ID as shown on the insurance Card: _____

Group ID as shown on the insurance Card:

_____

RELEVANT MEDICAL HISTORY:

Please check any of the following medical conditions, which apply to you:

☐ Depression / Mental Illness ☐ Head Injury ☐ Endocrine Problems ☐ Heart Problems ☐ Degenerative Disease ☐ Pain with Speaking ☐ Osteoporosis ☐ Muscle / Tendon Injury ☐ Pain with Swallowing ☐ Back Problems ☐ Joint Replacement ☐ Asthma ☐ Stroke / TIA ☐ Obesity ☐ Chronic or Season Allergies ☐ Alzheimer's / Dementia ☐ Stomach Problems ☐ Post-Nasal Drip ☐ GERD / Reflux Disorder ☐ Headaches ☐ Circulation / Vascular Problems ☐ Balance / Falling ☐ Arthritis ☐ Seizures / Epilepsy ☐ Fractures ☐ Cancer ☐ Neurological Disease / Disorder ☐ Vision Problems ☐ Diabetes ☐ Breathing Problems / Chronic Respiratory Problems ☐ Swallowing Problems or Dysphagia ☐ Other:

Please provide details regarding any of the medical conditions you identified above:

_____

_____

_____

Recent/Relevant Surgery: _____

List Current Medications:

_____

_____

If applicable, please list any specialists you currently see:

_____

_____

If applicable, please list any recent x-rays, MRI's, or diagnostic tests (to include rigid or flexible stroboscopy, ENT) that you have had and list results:

_____

_____

Contraindications/Precautions (a physician's order must include any precautions necessary for treatment):

_____

_____

□ None □ Seizure disorder r□ Braces (Orthopedic) □ Osteoporosis □ Cardiac □ Pacemaker or other metal implants □ Hip□ Lifting/weight limitations

□ Other: _____

Are you a smoker? □ Yes □ No □ Used to be for _____years

If yes, how much do you smoke on a daily/weekly basis?

Alcohol Intake? (How often/How much?)

Caffeine Intake? (How often/How much?)

Hydration/Water Intake? (How often/How much?)

RELEVANT SOCIAL HISTORY:

Employment/Work (job/school/play):

Work: □ Full Time □ Part Time □ Retired □ Student □Unemployed

Sports/Hobbies:_____

_____

Have you experience any significant social-emotional-mental stressors prior to the onset of the voice problem or within the last 6 months or year? Please provide relevant details.

_____

_____

PATTERNS of VOCAL USE:

Estimate # of hours used for social speaking:

Estimate # of hours used for work or employment-related speaking:

How long can you speak/talk before you feel fatigued or tired?

How long can you speak/talk before your voice quality deteriorates?

How long can you speak/talk before you experience pain?

Check any of these vocal use patterns/behaviors that apply to you:

□ Shouting/Yelling □Throat Clearing □Coughing □ Excessive Laughing □ Heavy Lifting/Pushing/Pulling □ Speaking In Loud, Noisy Environments

PATIENT SUMMARY:

Please describe your concerns:

_____

_____

Please list any illnesses, hospitalizations, or injuries that have affected/contributed to your concern:

_____

_____

Please describe events leading up to and following the illness :

_____

_____

Onset Date of Above Issue or concern: □ Abrupt or Sudden □ Gradual _____

What do you hope to accomplish with therapy services?

_____

_____

Please list any questions you would like to have answered:

_____

_____

SPEECH/LANGUAGE HISTORY:

Have you had speech therapy before? □ Yes □ No When? _____

Where? _____

Results/Area of Focus: _____

Reason for Discharge: _____

Do you have hearing loss/wear hearing aides? □ Yes □ No

Do you have or have you ever had difficulty chewing and swallowing? □ Yes □ No If yes, Please explain: _____

_____

_____

REHABILITATION INFORMATION:

Do you have any deficits from a prior illness/injury, which were not resolved with prior therapy? □ Yes □ No List: _____

_____

Do you use any adapted equipment (reacher, etc.), orthotics/splints, or have modifications? □ Yes □ No

List:_____

Do you use any adapted devices (walker, cane, wheelchair, etc)? □ Yes □ No

Describe what daily activities, leisure activities, and/or current occupation/job duties are being affected and how?

_____

_

_____

_____

_____

Are you experiencing any pain, which is new, unresolved, or attributed to your reason for seeking

therapy services at this time?

□ Yes □ No If yes, please explain (type/severity/location): _____

_____

_____

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This information will be kept confidential and used solely for the purpose of providing the appropriate care to the client. Thank you.