Speech Therapy Solutions Montana

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Adult Cognitive 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:_____

Employer: _____ 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 Problem ☐ 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 □ 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:_____

What brought on this cognitive change (i.e. an accident)? Please describe.

_____

_____

Have you experienced any significant social, emotional, or mental stressors prior to the onset of your TBI or cognitive changes, or, within the last 6 months or year? Please provide relevant details.

_____

_____

_____

_____

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

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):

_____

_____

Cognitive Questionnaire:

Check any of the following patterns/behaviors that apply to you:

□ Easily distractible	□ Poor organizational skills	□ Easily upset	□ Excessive Laughing
□ Headaches	□ Vision problems	□ Balance problems	□ Problems with sleep
□ Struggle to control impuls	□ Struggling to start or finish a tasks	□ Difficulty concentrating	

1. What aspects of your life do you find most challenging now? Please be specific.

2. Are some tasks easier than others? Please explain.

3. What is distracting to you? (i.e. music, other people talking, etc)

4. Are you able to remember things that happened in the past (last week or last year)

5. Are you able to remember things you need to do in the future (i.e. take out the trash on Tuesday)?

6. Can you shift from one activity to another (at work or home) with ease? What happens?

7. How do you respond to stressful situations?

8. Are you able to meet your responsibilities (ie. meal planning, bills, budgeting, etc)?

9. What do you see as your main area of struggle and how would you like us to help you?

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