Dysphagia-Voice-Therapeutics PLLC
Phone: (910) 217-1862
Fax: (910) 668-1340
Email: tamralowry@dysphagiavoice.com

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
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 ___________________

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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? __________________________

____

____

____

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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? ________________
____
____
____

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____

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: ____
____

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____

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: ____________________________

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☐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 Language Pathologist
If yes, please describe the nature of the evaluation and any results: ___________
____
____

Highest grade completed: _______________ Degree earned: _____________
Name of Institution(s): ____

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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: ____

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