

**Live Well Speech Therapy/Jackie Larsen**  
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**Adult Intake Form / History**

Client Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
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? \_\_\_\_\_

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How does your communication difficulties impact your life, social, work, hobbies, etc.? \_\_\_\_\_

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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? \_\_\_\_\_

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**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:

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Describe your current health status: \_\_\_\_\_

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Have you ever had surgery for a related issue?  Yes  No

Please describe: \_\_\_\_\_

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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: \_\_\_\_\_
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- 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: \_\_\_\_\_

\_\_\_\_\_

Educational Background: \_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_

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

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Person filling out the form: \_\_\_\_\_

Relationship to the client: \_\_\_\_\_

