Adult
General Intake Form

DATE: ____________

Identifying Information

FULL NAME: ______________________ DATE OF BIRTH: ____________

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER OCCUPATION: ____________

HOME: ____________ (STREET ADDRESS) ____ (APT) ____________ (CITY) ____ (STATE) ____ (ZIP CODE)

PHONE: ____________ EMAIL: ____________

EMERGENCY CONTACT: ____________ (NAME) ____________ (RELATIONSHIP) ____________ (PHONE)

Primary Care Physician

FULL NAME: ______________________ OFFICE PHONE: ____________

OFFICE: ____________ (STREET ADDRESS) ____ (APT) ____________ (CITY) ____ (STATE) ____ (ZIP CODE)

Insurance Information

Primary

INSURANCE COMPANY: ____________ PLAN NAME: ____________

POLICY #: ____________ GROUP: ____________ CONTACT: ____________

Secondary

INSURANCE COMPANY: ____________ PLAN NAME: ____________

POLICY #: ____________ GROUP: ____________ CONTACT: ____________

Medical History

Under a physician's care? ☐ YES ☐ NO If yes, please explain: ____________

Medications:

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

Please check all that apply:

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Asthma
- ☐ Breathing difficulty
- ☐ Cancer: ____________
- ☐ Colds often
- ☐ Cochlear implant(s)
- ☐ Concussion
- ☐ Confusion
- ☐ Dentures:
  - ☐ Upper ☐ Lower
- ☐ Diabetes
- ☐ Digestive difficulty
- ☐ Dyslexia
- ☐ Ear infections:
  - How often? ____________
- ☐ Ear tubes
- ☐ Encephalitis/Meningitis
- ☐ Falls
- ☐ Flu: How often? ________
- ☐ Intellectual disability
- ☐ Measles
- ☐ Memory problems:
  - ☐ Short-term ☐ Long-term
- ☐ Meniere's disease
- ☐ Mumps
- ☐ Noise exposure
- ☐ Neuromuscular disease
  - ☐ Amyotrophic Lateral Sclerosis
  - ☐ Epilepsy
  - ☐ Multiple Sclerosis
  - ☐ Muscular Dystrophy
  - ☐ Parkinson's Disease
  - ☐ Other: ____________
- ☐ PEG tube
- ☐ Pneumonia
- ☐ Poor appetite

Please check all that apply:

- ☐ Schizophrenia
- ☐ Seizures/convulsions
- ☐ Sensory integration disorder
- ☐ Sinusitis
- ☐ Sleeping difficulty
- ☐ Stroke
- ☐ Stuttering / cluttering
- ☐ Swallow difficulty
- ☐ Tinnitus
- ☐ Tonsillectomy
- ☐ Tracheostomy
- ☐ Traumatic brain injury:
  - ☐ Auto accident
  - ☐ Post-concussion
  - ☐ Other: ____________
- ☐ Vocal fold pathology:
  - ☐ Hoarseness
  - ☐ Laryngectomy
  - ☐ Polyps / Nodules
  - ☐ Speech valve
  - ☐ Other: ____________________

Any other serious illness, injury, or surgery? ______________________________

Communication

Do you have a speech problem? ☐ YES ☐ NO If yes, describe: ____________________

Previously evaluated? ☐ YES ☐ NO If yes, when? Results? ____________________

What therapy did you receive? ____________________

Do you have a hearing problem? ☐ YES ☐ NO If yes, describe: ____________________

Previously evaluated? ☐ YES ☐ NO If yes, when? Results? ____________________

Hearing aids? ☐ RIGHT ☐ LEFT

Do you have a vision problem? ☐ YES ☐ NO If yes, describe: ____________________

Glasses? ☐ YES ☐ NO

Do you have a history of learning disability? ☐ YES ☐ NO If yes, describe: ____________________

Swallowing

Are you on a modified diet? ☐ NO ☐ YES: ☐ Soft/chopped ☐ Pureed foods ☐ Thickened liquids (Nectar/Honey)

Do you cough/clear your throat during meals? ☐ YES ☐ NO If yes, describe: ____________________

____

Does food get "stuck" in your throat? ☐ YES ☐ NO If yes, types: ____________________

Do you have trouble swallowing pills? ☐ YES ☐ NO

Have you ever had the following swallow tests?

- ☐ Modified Barium Swallow Study (MBSS). Results: ____________________
- ☐ Fiberoptic Endoscopic Evaluation of Swallow (FEES). Results: ____________________

Any other therapy at this time? ☐ Physical therapy ☐ Occupational therapy ☐ Counseling/Psych.

Any additional comments?

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SIGNATURE ____________ RELATIONSHIP ____________ DATE ____________

Please return by email to info@kissimmeespeech.com, or fax to (321) 333-5682

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