Total Health
OFFERED BY STILLWATER MEDICAL CENTER

# Intake Speech Adult

**GENERAL INFORMATION:** **DATE:** ____ /____ /_____

| | | | |
|---|---|---|---|
| NAME: | | DATE OF BIRTH: | |
| ADDRESS: | CITY: | STATE: | ZIP: |
| HOME #: | CELL #: | OTHER CONTACT#: | |
| OCCUPATION: | EMPLOYER: | WORK #: | |
| EMAIL ADDRESS: | | | |
| REFERRING PHYSICIAN: | PRIMARY CARE PHYSICIAN: | | |
| ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ MARRIED - SPOUSE'S NAME: | | | |
| CHILDREN (INCLUDE NAMES, GENDER, AND AGES): | | | |
| | | | |
| | | | |

**PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY.**
**GENERAL INFORMATION:**

- Who lives in the home?

_____

- What languages do you speak? If more than one, which one is your dominant language?

_____

- What was the highest grade, diploma, or degree you earned?

_____

- Is there any problem with you language skills (ability to find the right words, express yourself, or understand others)?

_____

- Have you noticed changes in your cognition (memory, clarity, and speed of thinking, problem solving, or planning skills)?

_____

- Is there any problem with your speech (ability to produce clear speech sounds by the oral mechanism)?: _____

_____

- What do you think may have caused the problem? _____

_____

- Has the problem changed since it was first noticed? _____

_____

- Have you seen other speech-language specialist? Who and when? What were their conclusions or suggestions?

_____

_____

- Have you seen any other specialists (physicians, audiologist, psychologist, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions:

_____

_____

- Are there any other speech, language, or hearing problems in your family? If yes, please describe:

_____

_____

## MEDICAL HISTORY:

• Provide the approximate ages at which you suffered the following illnesses and conditions:

| | | |
|---|---|---|
| Adenoidectomy _____ | Asthma _____ | Chicken Pox _____ |
| Colds _____ | Croup _____ | Dizziness_____ |
| Draining ear _____ | Ear infections_____ | Encephalitis _____ |
| German Measles _____ | Headaches _____ | Hearing Loss _____ |
| High fever _____ | Influenza_____ | Mastoiditis _____ |
| Measles _____ | Meningitis_____ | Mumps _____ |
| Noise Exposure_____ | Otosclerosis_____ | Pneumonia _____ |
| Seizures_____ | Sinusitis _____ | Tinnitus_____ |
| Tonsillectomy _____ | Tonsillitis _____ | Other: _____ |

• Do you have any eating or swallowing difficulties? If yes, describe:

_____

_____

• List all mediations you are taking: _____

_____ _____

_____ _____

_____ _____

• Are you having any negative reactions to these medications? If yes, describe: _____

_____

_____

• Describe any major surgeries, operations, or hospitalizations (include dates):

_____

_____

_____

• Describe any major accidents:

_____

_____

• Provide any additional information that might be helpful in the evaluation or remediation process:

_____

_____

_____

## ALLERGY INFORMATION:

• Do you have any known allergies (e.g., foods, medicines, environmental agents)? If yes, please list and describe your response to contact with the allergen(s): _____

_____

_____

• Please describe immediate action to be taken in case of contact with allergen(s) _____

_____

• Person to contact in case of Emergency:_____ Phone #: _____

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**To the best of my belief, this information is true and correct.**

**Person completing form:**_____ **Relationship to patient:**_____

**Signed:**_____ **Date:** _____