Naples Speech Therapy

New Client Intake Form- Adult

*Please return prior to initial appointment.

Name:_____ Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Email:_____
Preferred contact method: ___ Phone ____ Text. ___ Email

Current or previous occupation:_____
Highest Level of Education: _____
Language(s) spoken:_____

Primary Physician: _____ Phone: _____

Describe the area of concern in detail. Please include approximate time of onset.

_____
_____
_____

Has the problem changed since it was first noticed? If so, please describe how and when.

_____
_____
_____

Please describe your prior level of function and how this decline has functionally impacted you.

_____
_____
_____

Please note any assistance you have in the home for activities of daily living; for example, does someone manage your medication, or remind you of upcoming appointments? Are you looking to increase independence with these tasks?

_____
_____
_____

Please rate your technology abilities on a scale from 0 to 10, (0 indicating no experience or familiarity, 10 indicating frequent use with games, FaceTime, email, etc.)

1 2 3 4 5 6 7 8 9 10

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

_____
_____
_____

Current Medications:

_____
_____
_____
_____

Additional Medical Diagnoses:

_____
_____
_____

Allergies:_____

Are you exhibiting any swallowing difficulties? If yes, please describe.

_____
_____
_____

Person completing forms:_____
Relationship to client: _____
Is the client legally responsible for self? Y / N
Signed: _____
Date:_____