ADULT INTAKE QUESTIONNAIRE

Today's Date: ________________

Name: ____ Date of Birth: ________________

GENERAL INFORMATION

1. What are your reasons for scheduling this appointment?

   ____

   ____

2. When was a speech/language difficulty first noticed?

   ____

   ____

3. How has the difficulty changed since it was first noticed?

   ____

   ____

4. In the past, what strategies/techniques have been helpful in regards to your speech/language?

   ____

   ____

5. Have you ever seen a speech-language pathologist for an evaluation and/or treatment?
   If so, where? ____
   For how long? ____
   Focus of treatment: ____
   Results of treatment: ____

6. How would changing your speech/language impact your life? (At home? At work? In social settings?)

   ____

   ____

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7. How do others react to your speech/language?

____

____

8. Is there anything else you think we should know about your speech/language?

____

____

9. What do you hope to gain from today's appointment?

____

____

BACKGROUND INFORMATION

1. Latest educational institution attended: ______________________________
2. What was the highest grade level, diploma, or degree earned?

   ____

3. Were you ever enrolled in a special class or have you received tutoring services?
   YES ____ NO ____
   If yes, please explain:

   ____

4. Did/does your speech/language affect your educational performance? If so, how?

   ____

   ____

5. Occupation:______________________________
   Employer: ______________________________
6. Does your speech/language affect your career? If so, how?

   ____

   ____

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7. Do you use English as a second language? If so, what is your native language?
   ____

8. Although an accent is not a disorder, do you find an accent is affecting your ability to communicate? Please explain.
   ____
   ____

MEDICAL HISTORY

1. Do you have a history of any of the following? (Please check any that apply)
   _____ seizures and/or convulsions
   _____ frequent colds and/or coughs
   _____ serious head injuries
   _____ high fevers
   _____ hearing difficulties
   _____ allergies
   _____ eye difficulties
   _____ serious illnesses
   _____ sinus problems
   _____ sore throats
   _____ difficulty swallowing
   _____ noise exposure
   _____ major surgery or hospitalization
   If so, for what? ______________________________ Date: __________
   _____ psychological/psychiatric treatment
   If so, for what? ______________________________ Date: __________
   _____ major accidents
   If so, please describe__________________________ Date: __________

2. Please list daily medications taken and for what:
   Medication Purpose
   ____
   ____
   ____

3. Please check any of the following that you wear:
   _____ hearing aid
   _____ dentures
   _____ glasses
   _____ prosthetic device

4. Are you presently under a doctor's care? YES ____ NO ____
   If yes, please complete below.

   Physician Name: ____
   Address:____
   City, State, Zip: ____

5. Have you seen any other specialists? (counselor, neurologist, audiologist, etc.)
   YES ____ NO ____
   If yes, please complete below.

   Physician/Specialist Name: ___________________________________
   Address: ____
   City, State, Zip: ____

   Physician/Specialist Name:___________________________________
   Address: ____
   City, State, Zip: ____

6. Do you have a diagnosed medical condition that you think is contributing to your communication difficulties?
   YES ____ NO ____
   If yes, please name the condition: _____________________________
   Please bring to the evaluation any diagnostic reports or other information related to this condition.

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