COLUMBUS SPEECH & HEARING
EST.1923

ADULT INTAKE QUESTIONNAIRE

Name: ______________________________ Today's Date: __________ 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 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?)

____

____

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?

____

____

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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?
   ____
   ____

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 affects 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 or convulsions
   - ☐ serious head injuries
   - ☐ hearing difficulties
   - ☐ eye difficulties
   - ☐ sinus problems
   - ☐ difficulty swallowing
   - ☐ frequent colds or coughs
   - ☐ high fevers
   - ☐ allergies
   - ☐ serious illnesses
   - ☐ sore throats
   - ☐ noise exposure
   - ☐ major surgery or hospitalization
     If so, for what? ______________________ Date: __________
   - ☐ psychological/psychiatric treatment
     If so, for what? ______________________ Date: __________
   - ☐ major accidents
     If so, for what? ______________________ Date: __________

2. Please list daily medications you take 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 explain: ______________________________

   Physician Name: ______________________________

   Address: ______________________________

   City, State, Zip: ______________________________
5. Have you seen any other specialists? (counselor, neurologist, audiologist, etc.)
   YES ☐ NO ☐
   If yes, please explain: ______________________________

   Physician Name: ______________________________

   Address: ______________________________

   City, State, Zip: ______________________________