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
   ☐ major surgery or hospitalization
   If so, for what? _____ Date: _____
   ☐ psychological/psychiatric treatment
   If so, for what? _____ Date: _____
   ☐ major accidents
   If so, for what? _____ Date: _____
   ☐ frequent colds or coughs
   ☐ high fevers
   ☐ allergies
   ☐ serious illnesses
   ☐ sore throats
   ☐ noise exposure
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: _____