CLIENT INTAKE FORM

Thank you for selecting Carolina Premier Speech Therapy for your care! We kindly ask that you complete this form prior to your initial evaluation. If possible, please mail this packet prior to your evaluation so that the clinician can review it.

GENERAL INFORMATION

Name: ___________________________________ Date of Birth: _____/____/____ Age: ____________________

Address: ____ Home Phone: ____________________________

City, State, Zip: ____Cell Phone: ______________________________

Email: ____

I prefer to be contacted via: __________ Home Phone __________ Cell Phone ____________ Email

Emergency Contact (name, phone number) ____

Occupation: ____________________________________ Employer: ____________________________________

Family Physician: ____ Phone: ____________________________

Address: ____

Marital Status: ______Never Married _____Married (Spouse's Name_____________________________)

______Divorced _____Separated ____Widowed

List any children (names, gender, ages): ____

What language(s) do you speak: __________________________ Primary Language_________________________

What is the highest form of education you received: ____

MEDICAL HISTORY

Indicate if you currently have, or have had, any of the following:

- ❑ Brain Injury (Year_____)
- ❑ Diabetes
- ❑ Hearing Loss
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Cancer (type) _________________
- ❑ Leukemia
- ❑ Meningitis
- ❑ Ear Infections
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke (Year_______)
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Dementia
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

____

____

____

Please list major hospitalizations/surgeries and indicate approximate dates. ____________________________

____

Please list any medications you are taking. ____

____

Please list any known allergies (medications, foods, latex, seasonal, etc.).______________________________

____

If your hearing has been evaluated please state when, where, and the results of the evaluation.

____

If your vision has been evaluated please indicate when, where, and the results of the evaluation.

____

Do you currently see any specialists (physician, audiologist, psychologist, neurologist, etc.)? Please list.

____

Please describe your biggest speech, language, or cognitive concerns.

____

____

Please describe your expectations/goals for receiving speech therapy services. ___________________________

____

Have you ever received speech therapy services? If so, please list when you were seen. ___________________

____

Do you require supervision/have difficulty with any of the following:

____ Getting Dressed	____ Laundry	_____Transportation
____ Toileting	____ Managing money (bills)	_____Grocery Shopping
____ Cooking	____ Time Management	_____Making Appointments
____ Eating	____ Staying Organized	_____Cleaning House

Please list your hobbies/interests. ____

____

Computer Use: _____Never Use _____ Occasionally Use _____ Frequently Use

Cellular Phone: _____Never Use _____ Occasionally Use _____ Frequently Use

Please provide any additional information you think would be helpful to the evaluation and treatment process:

____

____

____

Person completing this form: ____________________________ Relationship to Client: ______________________

How did you hear about Carolina Premier Speech Therapy?

_____ Internet Search/Website _____ Friend

_____ Social Media (Facebook, Twitter) _____ Other (Please specify__________________________)

_____ Physician Referral (Please specify: ___________________________)

Signature: ____

Printed Name: ____ Date: _________________