

## SPEECH, ACCENT, AND LANGUAGE TRAINING INSTITUTE, LLC

## **ADULT INTAKE FORM**

YOUR INFORMATION									
FULL NAME			GENDER AT BIRTH MALE F			LE 🖸 FEM	IALE	DOB	
AGE	AGE EMPLOYED?  No Full-time			□ Part-time □ Student			MARRIE	MARRIED SINGLE	
ADDRESS	I		CITY					ZIP	
PHONE CEL		CELL	LL HOME		WORK		EMAIL		
PLACE OF EMPLOYMENT/SCHOOL		IOOL			POSITION				
PRIMARY CARE PHYSICIAN (PCP)			L		PHONE			FAX#	
DESCRIBE YOU When did the pro noticed it, where/ normally occur?	blem begin, who								
Does your phys about your com What did he reco	nunication probl	erns em?							
Please list any therapeutic services you have received: Occupational, physical, or speech therapy, counseling, psychiatry. Select none if you have not received therapy.			TYPE	OF SERV	TICE	DA	TES	NA	ME OF PROVIDER
		e if							
NONE									
NONE									
FAMILY INF				NAME		A	GE	-	RELATIONSHIP
List all family member who live in your home		۱ 							

EMERGENCY CONTACT INFORMATION							
FULL NAME							
ADDRESS							
PHONE:		CEL	L D HOME	U WORK			
SOCIAL BACKGROU	ND						
Describe your childhood, including any diagnoses, accidents, or communication difficulties							
What is the highest level of education have you completed?							
Describe your social life. Do you gather with friends?							
How do you usually communicate with others? Circle all that apply:	□ Face-to-face □ Phone Call	<ul> <li>Email</li> <li>Text Message</li> </ul>	□ Video call ( □ Other	Facetime, Zoom)			
How has your communication problem impacted your work and social life?							
HEALTH BACKGRO	UND						
Has your hearing been tested	recently? Circle Yes	No DATE PLACE					
		RESULTS					
Describe any serious illnesses, injuries, or medical procedures you have experienced.							
List any environmental or food allergies.							
List current medications and their purposes							
Describe any other conditions or diagnoses							
Describe any difficulties with your voice, eating, swallowing, chewing, or textured foods							

Have you ever received a speech and language evaluation? If yes, where, when, and what were the findings?			
What do you hope to accomplish by participating in speech therapy?			
Insurance Carrier:		ID#	

Please provide any additional information that you feel may be helpful for your therapist.

Thank you for taking the time to complete this information.