Communication Sciences and Disorders
Speech-Language and Hearing Clinics
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Speech-Language Clinic: Adult Client Intake Form

Client Information

Legal first name: Legal last name:

Preferred or lived name: Pronouns:

Date of Birth: Occupation:

Phone 1: Mobile Carrier:

Phone 2: Mobile Carrier:

Email address:
Preferred language(s):

Mailing Address:
City: State: Zip:

Name of Primary Care Provider:

Emergency Contact Name:
Emergency Contact Relationship:
Emergency Contact Phone:
Emergency Contact Email:

If you are completing this form on someone's behalf:
Name of person completing form:
Relationship to client:
Phone: Email:

Contact person for scheduling or other questions:

Speech Clinic: Adult Client Case History

1. What are your reasons for coming to the clinic?

2. Please describe your current speech, language, cognition (memory, thinking, reasoning), voice, respiratory, and/or swallowing concerns:

3. When did the concern begin? Has it improved or worsened?

4. Please describe situations where it is better or worse:

5. How has this concern affected your social life, career, education, etc.?

6. Have you seen any other Speech-Language specialists? ◯ yes ◯ no

If so, who did you see?

When?

What were their conclusions or suggestions?

6. Have you seen any other doctors or specialists for this concern? ◯ yes ◯ no

This could include your doctor, physical or occupational therapists, psychologists, etc.

If yes, what specialists have you seen?

When did you see them?

What were their conclusions or suggestions?

7. Who lives in your home?

8. Who are your communication partners?

9. What languages do you speak? If more than one, what is your primary language?

10. What is the highest grade, diploma, or degree completed? Please list any other educational certifications.

11. What activities, hobbies, or groups are you involved in?

12. Please describe a typical day for you:
Please include times you wake up, times of meals, and other recurring activities.

13. Please select any medical conditions you have had:

- ☐ Allergies
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Chronic cough
- ☐ Concussion(s)
- ☐ Covid-19
- ☐ Depression
- ☐ Difficulty breathing
- ☐ Ear infections
- ☐ Encephalitis
- ☐ GERD/Acid Reflux
- ☐ Head injury
- ☐ Headaches
- ☐ High blood pressure
- ☐ Laryngopharyngeal reflux
- ☐ Low blood pressure
- ☐ Mastoiditis
- ☐ Measles/Mumps
- ☐ Memory or concentration concerns
- ☐ Meningitis
- ☐ Other lung/respiratory disease or problem
- ☐ Otosclerosis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sinusitis
- ☐ Stroke
- ☐ Voice concerns

14. Other relevant medical history:

15. Do you have hearing loss? ◯yes ◯no ◯unsure
    If yes, when was your last hearing test?

16. Do you have any difficulties with eating or swallowing? ◯yes ◯no
    If yes, please describe:

17. Please list any medications you take:
    If you need more room, please feel free to attach a list or use the back of this page.

18. Is there anything else you would like us to know?

This could include questions or goals that you have.

Signature of client or representative: _____ Date: _____