OUTPATIENT SPEECH THERAPY INTAKE SUMMARY

Name:_____ Date of Birth:_____ Today's Date:_____

Describe the problem that brings you to therapy:_____

Date problem began: _____

How did the problem begin and how has it been over time?:_____

_____

Have you had treatment for this problem? ❑ No ❑ Yes, what kind? _____

Since then, has your problem: ❑ Worsened ❑ Improved ❑ Stayed the same

Before this problem began, how well were you functioning? _____

What is your goal for therapy? _____

Do you have pain? ❑ No ❑ Yes, please describe _____

Have you had any tests recently? (X-Ray, MRI, CT Scan, etc.)_____

Do you live with: ❑ Spouse ❑ Child(ren) ❑ Parent(s)/Guardian ❑ Alone ❑ Other: _____

Are you currently working? ❑ No ❑ Yes, occupation:_____

What activities does your work require? (e.g., communication, vocal needs, telephone use, voice projection, cognitive functioning, etc.) _____

Do you work in areas of high noise or pollution? ❑ No ❑ Yes, please describe _____

_____

Do you have any eating or swallowing difficulties? ❑ No ❑ Yes, please describe _____

_____

Have you undergone any treatment for eating difficulties? ❑ No ❑ Yes, please describe _____

_____

Do you have difficulty with the following activities?

Household/Work activities	❑ No	❑ Yes	Money management.....	❑ No	❑ Yes
Understanding what is said to you	❑ No	❑ Yes	Talking	❑ No	❑ Yes

Describe what you do to keep physically fit:_____

Is there anything else you think your therapist will need to know?: _____

Past Medical History: Do you have any previous history of the following conditions?

Seasonal Allergies:	❑ No	❑ Yes	Metal Implants:	❑ No	❑ Yes
Reflux:	❑ No	❑ Yes	Fibromyalgia:	❑ No	❑ Yes
Sinusitis:	❑ No	❑ Yes	Seizures:	❑ No	❑ Yes
Pituitary Dysfunction:	❑ No	❑ Yes	Severe Emotional Disturbance:	❑ No	❑ Yes
High Blood Pressure:	❑ No	❑ Yes	Cancer:	❑ No	❑ Yes
Heart Condition/Pacemaker:	❑ No	❑ Yes	Respiratory Disorders/Short of breath:	❑ No	❑ Yes
Strokes:	❑ No	❑ Yes	Excessive Fatigue:	❑ No	❑ Yes
Diabetes:	❑ No	❑ Yes	Frequent/Severe Headaches:	❑ No	❑ Yes
Broken Bones (Fractures):	❑ No	❑ Yes	Unexplained Weight Loss/Gain:	❑ No	❑ Yes

Are you pregnant now or is there a chance you could be? ❑ No ❑ Yes

Have you taken steroids for a prolonged period of time? ❑ No ❑ Yes

→→→→→→→ OVER →→→→→→→

OUTPATIENT SPEECH THERAPY INTAKE SUMMARY

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____

Preferred Mode of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Other_____

ALLERGIES Do you have any allergies? ❑ No ❑ Yes, please list:	**REACTION**

OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses or significant conditions? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

PREVIOUS PROCEDURES / SURGERIES Did you have any other previous procedures / surgeries? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

CURRENT MEDICATIONS, INCLUDING HERBALS Are you currently taking any medications, including herbals? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**
❑ See attached list			

Do you identify with another gender? ❑ No ❑ Yes, which gender do you identify with? _____

I acknowledge that the above is true to the best of my knowledge and am aware that if I miss three scheduled visits within the course of treatment that my treatment may be discontinued per therapist discretion.

_____ _____ _____
Time Date Patient Signature