Tel: 408.982.3340/Fax:669.247.0974
E-mail: info@keys2c.com
Website: www.keys2c.com

Adult Intake Form

Today's Date _____ Client's Name: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Is English your primary language? ☐ Yes ☐ No
If no, what is your primary language?
_____

Referring physician's name and phone number:
_____
_____

Speech or language diagnosis if known:

☐ Dysarthria
☐ Apraxia/Dyspraxia
☐ Aphonic (without voice)
☐ Expressive aphasia
☐ Phonological delay
☐ Receptive-expressive language delay
☐ Other
☐ Unknown

Please describe your speech difficulty:
_____
_____

When did the difficulty begin?
_____
_____

Relevant medications/dosages:
_____
_____

Was the onset gradual or sudden?
_____
_____

Was anything done about your difficulty after it was first noticed? If so, please describe:
_____
_____
_____

Do you currently, or have you ever, experienced any pain associated with this problem?

☐ Yes ☐ No

How would you rate the severity of the problem now?

_____
_____

Other relevant medical history/diagnoses/surgery:

_____
_____

Describe any changes that you have noticed in your speech problem since it began:

_____
_____
_____

Is the difficulty worse at certain times as compared to other times? If yes, please explain:

_____
_____
_____

Have you had a speech and language evaluation at another clinic in the past? If yes, when and where?

_____
_____
_____

Have you received speech/language therapy in the past? If yes, when, where and for what reason?

_____
_____
_____

Have any other members of your family had speech/language and/or hearing difficulties?

☐ Yes ☐ No

Is there anything else about either your history or your current condition that you feel is important to mention?

_____
_____
_____