Widener University

Institute for Speech-Language Pathology
College of Health and Human Services

ADULT INTAKE FORM

Date Form Completed: ______________________

PERSONAL INFORMATION

Client Name: ____

Date of Birth: ______________ Age: __________ Gender: ☐Male ☐Female ☐Other

Address: ____

Person filling out this form: ______________________ Relationship to Client: ___________

Contact Information:

Address: ____

Preferred Phone: ____________________________ Alternate Phone: _______________

E-mail Address: ____

What is your primary language? English Other: ________________________

What other languages do you speak and/or understand? _______________________________

REASON FOR REFERRAL

Who referred you to the SLP Clinic? ____

Why? ____

What are your hopes or goals for scheduling an appointment with the SLP Clinic?

____
____
____
____

Check any concerns you may have about your speech, language, and/or swallowing skills:

☐ articulation (difficulty producing sounds, sound distortions)

☐ language (difficulty formulating sentences, poor vocabulary, difficulty understanding language or what people say)

☐ voice (raspy, hoarse, weakness, discomfort, strain, pitch breaks)

☐ fluency (stuttering, stammering, getting stuck on words)

☐ swallowing (difficulty/pain when swallowing, food getting stuck in throat, drooling)

What concerns you *most* about your speech, language, and/or swallowing skills?

____
____
____
____

When was the problem first noticed? ____

In the last 6 months, has the problem gotten: ☐better ☐worse ☐stayed the same

Do you consider the problem to be: ☐mild ☐moderate ☐severe

What, if anything makes the problem better? _______________________________________
____
____

What, if anything makes the problem worse? _______________________________________
____
____

How has this problem affected your participation in the following aspects of daily life:

Activities of Daily Living (e.g., cooking, cleaning, dressing, personal hygiene, etc.)?
____
____

Leisure activities and hobbies?
____
____

Social life and community involvement?
____
____

School?
____
____

Work?
____
____

THERAPEUTIC HISTORY

Have you ever had a speech, language, and/or swallowing evaluation? ☐Yes ☐No
If yes, where, when, and why?

____
____

Have you ever received speech and language therapy services? ☐Yes ☐No

If yes, where and when?____

Have you ever had your hearing tested? ☐Yes ☐No

If yes, where and when?____

Have you ever been evaluated by or received services from any of the following specialties?:

☐Physical Therapy (PT)
☐Occupational Therapy (OT)
☐Psychology/Counseling
☐Social Work
☐Other

If yes, please describe the date(s) and reason(s) for evaluation and/or treatment:
____
____
____
____

***If you have had any other evaluations, please submit a copy of the reports with this form**

MEDICAL HISTORY

Have you ever experienced any of the following medical issues? Please check all that apply:

___	Asthma	___	Smoking	___	Measles
___	Allergies	___	Chronic cough / choking	___	Mumps
___	Arthritis	___	Chronic heartburn	___	Rheumatic fever
___	Mouth breathing	___	Pain when swallowing	___	Scarlet fever
___	Snoring	___	Nasal regurgitation	___	Meningitis
___	Vision problems	___	Pneumonia	___	Neurological disease

___ Hearing loss
___ Dental problems
___ Adenoidectomy
___ Heart problems
___ Nutrition problems
___ Headaches
___ Memory loss
___ Difficulty concentrating
___ Difficulty sleeping
___ Encephalitis
___ Head injury
___ Stroke
___ Blood disease
___ Cancer

Have you ever been hospitalized or undergone major surgery? ☐Yes ☐No

If yes, please describe the date(s) and reason(s):

____
____
____
____

Please describe any other health issues (accidents, injuries, operations, illnesses, diseases):

____
____
____
____

Please list all medications you are currently taking:

____
____
____
____

FAMILY/SOCIAL HISTORY

Who lives at home with you?

____
____

What is your marital status?

☐Single
☐Married/Domestic Partnership
☐Divorced
☐Other

Do you have children? ☐Yes ☐No If yes, how many? ____________

Who are your primary communication partners (i.e., who do you speak with on a daily basis)?

____
____

Do you have a family history of:

Speech/language concerns? ☐Yes ☐No

Learning disabilities? ☐Yes ☐No

Reading problems? ☐Yes ☐No

What are your hobbies?

____
____
____
____

Is there anything else you would like to share about your family or social history?

____
____
____
____

EDUCATION/WORK HISTORY

What is your highest level of education?

☐Grade school
☐High school
☐College
☐Post-graduate
☐Other/Prefer not to answer

Are you currently employed? ☐Yes ☐No

If yes, what is your occupation?____
____

Were you employed previously? ☐Yes ☐No

If yes, what was your occupation?____
____

Is there anything else you would like to share about your education or work history?

____
____
____
____