SAINT MARY'S COLLEGE
NOTRE DAME • INDIANA

Adult Intake Form *must be answered

Client Background Information	Date:	Office use:		
* Name:	*Birthday:	Gender:	M	F
*Address:		Age:		
*City:	*State:	*Zip Code:		
Home phone:	Cell phone:			
Emergency Contact				
*Name:	Relationship:	*Phone#:		

Primary Physician	
Name:	Clinic:
Phone#:	Address:
Referring Physician/Referral Source	
Name:	Relationship:
Phone#:	Address:

REASON FOR REFERRAL:

Responsible Party of Client (Self/Spouse/ Parent/Caregiver/Guardian) Please Circle OR Fill in Answers							
*Name:				*Birthday:			
*Address:			*City:		*State:	*Zip Code:	
*Phone:	Home:		Cell:		Work:		
E-Mail:			Agree to contact by email: YES NO				
Circle Employment Status:	Full Time	Part Time	Self Employed	Stay at home Parent/ Caregiver	Retired	Disability	Unemployed
Occupation:			Employer:				
Address:			City:		State:	Zip Code:	

Family Information (Please Circle OR Fill in Answers)							
Self:				Spouse/Other:			
Cell phone:				Cell phone:			
Home phone:				Birthday:			
Email:				Email:			
Guardian/Caregiver other than Parent:							
Lives With:	Alone	Spouse	Other:				
Primary Language:	English	Spanish	Other:	Secondary Language:	Spanish	English	Other:
Children(ages)							
Grand-children(ages)							

Family Information: Multicultural information
Are there any holidays or religious days you are not available for therapy? If so, please list.
Are there specific cultural norms of which we should be aware?
The clinic personnel are almost exclusively female. Will this pose a problem for you? YES NO
Who is the primary contact for making decisions about the client?
Please list other cultural/social practices that would be helpful knowledge for your Clinician:

Current Medical History(Please Circle OR Fill in Answers)						
Currently under a Physician's care	No Yes	For What?				
Recent Surgeries:	No Yes	Describe and Date of Surgery:				
Overnight Hospitalizations:	No Yes	When and for What?				
Hearing Deficit:	No Yes	Date of Last Exam:	Please Explain:			
Visual Deficit:	No Yes	Date of Last Exam:	Please Explain:			
Respiratory Issues:	NO	Yes Please Explain:				
Other Procedures:	X-ray Date:		CT Scan Date:	MRI Date:	Sleep Study Date:	
Equipment Used:	Glasses	Eye Patch	Hearing Aides	Cochlear Implant	Splints	Stander
	Braces (AFO – SMO)		Wheelchair	Walker	Bath Chair	Toilet Seat
Medications (please list):						
ALLERGIES (please list):						

Consulting Physicians Currently Treating Client:			
Name	Specialty	Location	Phone#

Activities of Daily Living: (Please Circle, Check OR Fill in Answers)				
Any issues with:	Yes	No	With assistance	Independently
Communication				
Writing				
Feeding				
Swallowing				
Walking				
Sitting				
Toileting				
Does client understand what is said?	YES Please Explain:			NO
Does client communicate his/her needs?	YES How?			NO
Does client make his own decisions?	NO, If no, who is power of attorney or health care decision maker?			YES

Therapy History: (Please Circle OR Fill in Answers)						
Are you, or were you enrolled in any therapy or other medical programs?						
NO	YES - Please Explain:					
If Yes, what do/did you receive:	OT	PT	ST	Nursing	Dietician	Other:
If Yes, how often is/was each visit :	Weekly	Twice a Month	Monthly			
Are you currently in a speech therapy program? YES NO						
May we contact your therapists? YES NO Name and contact information:	Therapist Name: Address: City, State & Zip:					
What are your Goals related to speech therapy:						
1.						
2.						
3.						

Additional Therapy/Programs: (Please Circle OR Fill in Answers)		
Do you attend any adult day programs:	NO	YES - If yes, Where and how often:
Are you currently receiving outpatient therapy:	NO	YES - If yes, Where and how often:
Are you currently receiving any other services:	NO	YES - If yes, Where, what and How often:

Communication and Language: (Please Circle OR Fill in Answers)												
Percentage of Speech Understood by:	Spouse				Family Member				Stranger			
	<25%	50%	75%	100%	<25%	50%	75%	100%	<25%	50%	75%	100%
How do you explain your wants and needs?												
Can you follow verbal commands:	NO	YES - Please Explain any problems that you have:										
Can you read:	NO	YES - Please Explain any problems that you have:										
Can you write:	NO	YES - Please Explain any problems that you have:										

Swallowing: (Please Circle OR Fill in Answers)		
Are you on a restricted diet:	NO	YES - Please Explain any problems that you have:
Are you on a modified diet:	NO	YES - Please Explain any problems that you have:
Are your liquids restricted:	NO	YES - Please Explain any problems that you have:
Are your liquids thickened:	NO	YES - Please Explain any problems that you have and the results of the test:
Have you had a swallow study:	NO	YES - Please Explain any problems that you have:
Are you being treated for a swallowing problem:	NO	YES - Please Explain any problems that you have:
Do you have reflux:	NO	YES - Please Explain any problems that you have:
Are you on medication for reflux:	NO	YES - Please Explain any problems that you have:

Fine Motor Skills: (Please Circle OR Fill in Answers)		
Are buttons/snaps/zippers difficult for you:	NO	YES Please explain:
Do you get dressed on your own:	NO	YES Please explain:
Do you have trouble with handwriting:	NO	YES Please explain:
Do you have trouble with key boarding/typing:	NO	YES Please explain:
Do you have trouble with texting:	NO	YES Please explain:
Do you use utensils independently:	NO	YES Please explain:
Please circle: Left-handed Right-handed		

Sensory Motor/Cognitive Function: (Please Circle OR Fill in Answers)		
Does Attention interfere with daily routine:	NO	YES - Please explain:
Do memory problems interfere with daily routine:	NO	YES - Please explain:
Does lack of judgment interfere with daily routine:	NO	YES - Please explain:
Are you distracted by background noise:	NO	YES - Please explain:
Has there been a change in personality	NO	YES - Please describe:
Do you get tired easily:	NO	YES - Please explain:

List Favorite Activities/Hobbies:
1.
2.
3.
4.

How is frustration/anger expressed?

What is motivating for you?

What is your biggest concern at this time?

What would you like to be able to accomplish through speech therapy at Saint Mary's College Judd Leighton Speech and Language Clinic

Please List any additional information that may be helpful on the bottom or back of this page. You may attach a separate page if desired.

If you have any questions please call 574-284-5210

Please return to:
Saint Mary's College
Judd Leighton Speech & Language Clinic
34 Madeleva Hall, Ste. 150
Notre Dame, IN 46656
or
FAX: 574-284-5088