BYC
BECAUSE YOU CAN

5225 Central Ave, Saint Petersburg, FL 33710

General Adult Intake Form

DEMOGRAPHIC INFORMATION	
Patient's legal name: ______________ *Last* ______________ *First*	**Patient's date of birth (MM/DD/YYYY):** ______________
Today's date (MM/DD/YYYY): ______________	**Name of person completing this form:** ______________ **Relationship to patient:** ______________
Who referred you to our program? ______________	**Primary language spoken at home:** ______________
Patient's address: ______________ *Street* ______________ *City* *State* *Zip code*	**Need an interpreter?** ☐ Yes ☐ No

GUARDIAN INFORMATION *(if applicable)*	
Name ______________ *Last* ______________ *First*	**Email address:** ______________
Phone number(s): **Home:** ______________ **Cell:** ______________ **Work:** ______________	Preferred method of contact? ☐ Home ☐ Cell ☐ Work ☐ Email

Address: *(if different from patient's)*

Street *City* *State* *Zip code*

PURPOSE OF VISIT

What specific questions do you have?

MEDICAL HISTORY

Date of onset/diagnosis: ___________________

Please describe:

If known, what is the cause?

Has the difficulty changed since the onset/initial diagnosis? Please describe:

Current medications: *(if applicable)*

Name *Purpose*

Name *Purpose*

Name *Purpose*

Please check all that apply:	**Has the patient ever been evaluated or treated by one of the following?**
☐ Acid reflux ☐ Arthritis ☐ Asthma ☐ Bronchitis ☐ Cerebral palsy ☐ Chronic colds ☐ Chronic laryngitis ☐ Diabetes ☐ Emotional or psychological issues ☐ Facial nerve palsy ☐ Head injury ☐ Hearing loss ☐ Heart attack ☐ Heart troubles ☐ Huntington's or Parkinson's Disease ☐ Hypertension ☐ Intellectual deficits, MR ☐ Neurological conditions ☐ Pneumonia ☐ Seizures ☐ Sinusitis ☐ Stroke ☐ Thyroid issues ☐ Voice issues or changes ☐ Vocal polyps or nodules ☐ Other: ______________________	☐ Audiology ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Other: ______________________ ______________________ ______________________ **If yes to any of the above, please give the location and date:** ______________________ ______________________ ______________________ ______________________ **Other physicians/professionals involved in the patient's care:** ______________________ ______________________ ______________________ ______________________
Has the patient had a recent setback due to hospitalization or medical condition? ☐ Yes	

☐ No

If yes, what was the patient's prior level of function?

____

____

____

Has the patient's hearing been evaluated?

☐ Yes

☐ No

If yes:

Date of most recent evaluation:

____

Name of provider/facility:

____

Results:

____

If no, are there any concerns? Please describe:

____

____

____

Has the patient's vision been evaluated?

☐ Yes

☐ No

If yes:

Date of most recent evaluation:

____

Name of provider/facility:

____

Results:

____

If no, are there any concerns? Please describe:

____

____

____

List any hospitalizations in the last 5 years:

____

Date *Reason*

Pain assessment:

What is the patient's current state of health?

☐ Excellent

Date *Reason*	☐ Average/fair
Date *Reason*	☐ Poor
Date *Reason*	**Is the patient currently experiencing any pain?**
Date *Reason*	☐ Yes ☐ No
Date *Reason*	**If yes, please describe:**
Date *Reason*	

Allergies:

DYSPHAGIA HISTORY *(if applicable)*

Did the patient have any difficulty with swallowing (e.g. – choking with liquids, difficulty managing solids, trouble transitioning to textures, poor weight gain, reflux, etc.)?

☐ Yes

☐ No

If yes, please explain:

How has the swallowing problem progressed?

☐ Suddenly

☐ Gradually

When was the swallowing problem first identified? ______________________

Have symptoms gotten better or worse over time?

☐ Better

☐ Worse

What helps or worsens symptoms?

___

___

Describe the patient's current diet:

___

___

Please check which food consistencies are the easiest for the patient to swallow:

☐ Solids (e.g. – meat, raw vegetables)

☐ Pastes (e.g. – mashed potatoes, apple sauce)

☐ Liquids (e.g. – juice, water, coffee)

Is the patient unable to swallow any of the above? ☐ Yes ☐ No

If yes, which ones?

___

When eating, does the patient:

1. Have difficulty chewing food? ☐ Yes ☐ No
2. Have difficulty moving food from the front to the back of their mouth? ☐ Yes ☐ No

After swallowing:

1. Does some food remain in the mouth? ☐ Yes ☐ No
2. Does some food remain in the throat? ☐ Yes ☐ No

3. Does some food feel like the patient ever chokes or needs to cough often while eating? ☐ Yes ☐ No

If yes to #3, check which one: ☐ Liquids ☐ Solids

Is it painful to swallow? ☐ Yes ☐ No

Has the patient had any previous swallowing evaluations? ☐ Yes ☐ No

If yes:

Date of evaluation: ______________________

Name of provider/facility: ______________________

Reason: ______________________

Results: ______________________

Is there anything else we should know about the patient's medical history or current medical status? Please explain:

____

____

____

FAMILY HISTORY

People currently living in the household:

Relationship to patient	*Age*

Please check if any immediate/extended family has a history of the following:

☐ Articulation disorders
☐ Language disorders
☐ Learning disabilities
☐ Fluency/stuttering problems
☐ Motor disorders

If yes to any of the above, please explain:

____

CURRENT COMMUNICATION SKILLS

Currently, does the patient:

1. Respond to their name? ☐ Yes ☐ No ☐ Sometimes
2. Point to objects when asked? ☐ Yes ☐ No ☐ Sometimes
3. Follow simple directions? ☐ Yes ☐ No ☐ Sometimes
4. Get objects from another room when asked? ☐ Yes ☐ No ☐ Sometimes
5. Point to body parts when asked? ☐ Yes ☐ No ☐ Sometimes
6. Point to pictures when asked? ☐ Yes ☐ No ☐ Sometimes
7. Answer simple questions? ☐ Yes ☐ No ☐ Sometimes
8. Point to family members when asked? ☐ Yes ☐ No ☐ Sometimes
9. Understand prepositions (e.g. – in, on, under, next to)? ☐ Yes ☐ No ☐ Sometimes
10. Understand color and size words (e.g. – red, big, small)? ☐ Yes ☐ No ☐ Sometimes
11. Engage in pretend/imaginary play? ☐ Yes ☐ No ☐ Sometimes

Which of the following describe(s) how the patient communicates? Check all that apply.

☐ Babbling
☐ Communication board(s)/book(s)
☐ Communication device(s)
☐ Eye contact, facial expressions
☐ Grammatically correct sentences
☐ Objects/tangible symbols
☐ Pictures
☐ Pointing, gesturing, vocalizing
☐ Pulls person to desired object
☐ Sentences with some errors
☐ Sign language
☐ Single words
☐ Three- to four-word sentences
☐ Three-word phrases

- ☐ Two-word phrases
- ☐ Writing
- ☐ Other: ______________________

Please provide examples of the patient's communication/messages (e.g. – vocalizations, signs, picture/symbol use, etc.):

____

Does the patient socialize with others?

- ☐ Yes
- ☐ No

Do others have difficulty understanding the patient's speech?

- ☐ Yes
- ☐ No

Does the patient appear frustrated when they are not understood?

- ☐ Yes
- ☐ No

Does the patient repeat sounds or words when speaking?

- ☐ Yes
- ☐ No

FINANCIAL/INSURANCE INFORMATION

Primary insurance **Health insurance provider:**	**Secondary insurance** *(if applicable)* **Health insurance provider:**
Policy holder's legal name: *Last* *First*	**Policy holder's legal name:** *Last* *First*
Policy number:	**Policy number:**

______________________________	______________________________
Group number: ______________________________	**Group number:** ______________________________
Check which applies: ☐ HMO ☐ PPO ☐ N/A	**Check which applies:** ☐ HMO ☐ PPO ☐ N/A
Primary Care Physician's (PCP) name: ______________________________	**Primary Care Physician's (PCP) name:** ______________________________
PCP's phone number: ______________________________	**PCP's phone number:** ______________________________