Because You Can LLC
5225 Central Ave, St. Petersburg, FL, 33710

PATIENT INTAKE FORM

Patient Information	
Name: _____	Date of birth (mm/dd/yyyy): _____
Today's date: _____	Name of person completing this form: _____
Who referred you to our program?: _____	Relationship to patient: _____

Parent/Guardian Information (if applicable)	
Name(s): _____	
Street Address: _____ _____ City, State: _____ Zip Code: _____	Patient's address: (If different from parent/guardian) Street: _____ City, State: _____ Zip Code: _____
Telephone Number (s): Home: _____ Work/cell: _____	Primary language spoken at home: _____ Need an interpreter? Yes/No
Email address: _____	

Purpose of Visit
What specific questions do you have? _____ _____ _____

Medical History
Date of onset/diagnosis: _____ Please describe the speech/language difficulties: _____ _____ _____

If known, what is the cause of the speech/language difficulty?

_____

Has the speech/language difficulty changed since first diagnosed? Please describe:

_____

_____

_____

Please check all that apply.

☐ Heart attack
☐ Heart troubles
☐ Hypertension
☐ Diabetes
☐ Stroke
☐ Chronic laryngitis
☐ Acid reflux
☐ Ear infections
☐ Meningitis
☐ Seizures
☐ Head injury
☐ Neurological conditions
☐ Shingles
☐ Bronchitis
☐ Arthritis
☐ Sinusitis
☐ Pneumonia
☐ Asthma
☐ Thyroid issues
☐ Hearing loss
☐ Cerebral palsy
☐ Intellectual deficits, MR
☐ Cleft palate
☐ Chronic colds
☐ Facial nerve palsy
☐ Emotional or psychological issues
☐ Huntington's or Parkinson's Disease
☐ Voice issues or changes
☐ Vocal polyps or nodules

Other: _____

_____

Have you ever been evaluated or treated by one of the following?

☐ Physical Therapy ☐ Audiology
☐ Occupational Therapy ☐ Speech Therapist

Other: _____

_____

If yes to any of the above, give the location and date:

_____

_____

Other physicians/professionals involved in your care:

_____

_____

Have you had a recent setback due to hospitalization or medical condition? ☐ Yes ☐ No

If yes, what was your prior level of function?

_____

_____

_____

<u>Hearing</u>

Evaluated? ☐ Yes ☐ No

Where? _____

When? _____

Results: _____

Not evaluated but have concerns? ☐ Yes ☐ No

Describe: _____

<u>Vision</u>

Evaluated? ☐ Yes ☐ No

Where? _____

When? _____

Results: _____

Not evaluated but have concerns? ☐ Yes ☐ No

Describe: _____

Please list any hospitalizations within the last 5 years:	**Pain Assessment**
Date/Reason for hospitalization:	What is your current state of health?
	☐ Excellent ☐ Average-fair ☐ Poor
	Are you currently experiencing any pain?
	☐ Yes ☐ No
	If yes, please describe:
Allergies:	**Current Medications:**

Dysphagia History

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 long have you had swallowing problems? ☐ Sudden ☐ Gradually

When was it first identified?_____
Have symptoms gotten worse or better over time?_____

What helps or worsens symptoms? _____

Describe current diet:

Circle the following food consistencies that are easiest to swallow:

SOLIDS (ie meat, raw vegetables)

PASTES (ie mashed potatoes, apple sauce)

LIQUIDS (ie, juice, water, coffee)

Are you unable to swallow any of the above? ☐ Yes ☐ No

If yes, which ones? _____

When eating, do you:

Have difficulty chewing the food? ☐ Yes ☐ No

Have difficulty moving the food from Front to back of the mouth? ☐ Yes ☐ No

After swallowing, does some food remain in the mouth? ☐Yes ☐ No

After swallowing, does some food remain in the throat? ☐ Yes ☐ No

After swallowing, does some food feel like you ever choke or need to cough often while eating? ☐ Yes ☐ No

If Yes, circle which one: Liquids/Solids

Is it painful to swallow? ☐ Yes ☐ No

Have you had any previous swallowing evaluations? ☐ Yes ☐ No

If yes. Where? _____
If yes, When? _____
For what reason? _____
What were the results? _____

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

Please explain:

_____

_____

Family/ Information History	
People currently living within the household: 1. _____ Age: _____ 2. _____ Age: _____ 3. _____ Age: _____ 4. _____ Age: _____ 5. _____ Age: _____	Do any immediate or extended family members have a history of: Language Disorders? ☐ Yes ☐ No Articulation Disorders? ☐ Yes ☐ No Learning Disabilities? ☐ Yes ☐ No Motor Disorders? ☐ Yes ☐ No Fluency/ Stuttering Problems? ☐ Yes ☐ No If yes to any of the above, please explain: _____

	_____ _____

Current Communication Skills			
Currently, does the patient?:			
Respond to his/her name?	Yes	No	Sometimes/Some
Point to objects when asked?	Yes	No	Sometimes/Some
Follow simple directions?	Yes	No	Sometimes/Some
Get objects from another room when asked?	Yes	No	Sometimes/Some
Point to body parts when asked?	Yes	No	Sometimes/Some
Point to pictures in books when asked?	Yes	No	Sometimes/Some
Answer simple questions?	Yes	No	Sometimes/Some
Point to family members when asked?	Yes	No	Sometimes/Some
Understand prepositions? (e.g., in, on, under, next to)	Yes	No	Sometimes/Some
Understand color and size words? (e.g., red, big, small)	Yes	No	Sometimes/Some
Engage in pretend/imaginary play?	Yes	No	Sometimes/Some

Current Communication (cont.)

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

- ☐ Pointing, gesturing, vocalizing
- ☐ Eye contact, facial expressions
- ☐ Babbling
- ☐ Pulls person to desired object
- ☐ Objects/ tangible symbols
- ☐ Pictures
- ☐ Communication boards/ book

☐ Sign language
☐ Single words
☐ Two word phrases
☐ Three to four word sentences
☐ Sentences with some errors
☐ Grammatically correct sentences
☐ Writing
☐ Communication device(s)
☐Other (please specify)_____

Please provide examples of the patient's communicative/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 he/she is not understood? ☐ Yes ☐ No Does the patient repeat sounds or words when speaking? ☐ Yes ☐ No

Financial/Insurance Information	
Primary Insurance Information:	
Health Insurance Provider: _____	Policy Holder's Name: _____
Policy Number (s) for Patient: _____	Group Number:_____
Primary Care Physician Name: _____	HMO or PPO (circle one if applicable)

Street Address: _____ _____	Phone Number: _____
Zip Code: _____	City, State: _____
Secondary Insurance Information (if applicable)	
Health Insurance Provider: _____	**Policy Holder's Name:** _____
Policy Number (s) for Patient: _____	**Group Number: _____**