PRECISION THERAPY, LLC
Adult Intake Form
Phone: (315) 889-1690
Email: precisiontherapyllc@gmail.com

OFFICE USE ONLY	
ID	
DATE	
OTHER	

ADULT INTAKE FORM

Please answer the following questions. **Please attach copies of the following documents:**

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).
- PLEASE RETURN THIS INFORMATION TO YOUR THERAPIST AT YOUR S FIRST THERAPY SESSION.

CLIENT'S INFORMATION		
FULL NAME	GENDER ☐ Male ☐ Female	DOB
CURRENT AGE	SOCIAL SECURITY	
PRIMARY CARE PHYSICIAN (PCP)	PCP PHONE	
DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs. (speech/communication/ cognition/swallowing)		
Why are you seeking speech-language services?		
How did you learn about us?		

FAMILY INFORMATION			
With whom do you live? (Check all that apply)	☐ Spouse/Significant other	☐ Siblings(s)	☐ Parent(s)
	☐ Children	☐ Grandchildren	☐ Other:

In the table to the right, list all family members who live in the same home.	NAME	AGE	RELATION TO CLIENT

Continue to next page.

Do you have any family pets? (List name and type)			

ADDITIONAL CLIENT INFORMATION			
ADDRESS		CITY	ZIP
PHONE 1	☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2	☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
OCCUPATION		HIGHEST LEVEL OF EDU COMPLETED	

EMERGENCY CONTACT INFORMATION			
FULL NAME			
ADDRESS		CITY	ZIP
PHONE 1	☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2	☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
Are there any other languages spoken in the home? If yes, which language(s) and how often?			

PRESENTING DISORDER	
Have you ever received speech language therapy in the past? Where? For what reason?	
Was the onset of difficulty gradual or sudden? Describe the severity. Any associated pain? If yes, please describe.	
Are there conditions that improve or exacerbate the problem?	
How does this affect your job or other aspects of your life?	
Do members of your family have a similar problem? Please explain.	

MEDICAL HISTORY	
Describe your general health? Excellent, Good, Fair, Poor	
Have you had any serious accidents, chronic illnesses?	
Have you ever been hospitalized? Had surgery?	
Have you ever received any medical diagnosis impacting speech, communication or swallowing?	
Do you have difficulty with your hearing?	
Do you present with any physical disabilities?	
What medications are you currently taking? For what?	

Thank you for taking the time to complete this information about your child.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE