BEAUREGARD HEALTH SYSTEM

Beauregard Health System Rehabilitation Services
Adult Speech Pathology Intake Form

Today's Date: ____ / ____ / ____ M/D/YR

Patient's Name: ____________________

Date of Birth: ____________ M/D/YR Age: ______

Gender: ☐ Male ☐ Female

Address:		
Apt.		
CITY:	STATE:	ZIP CODE:

Home Phone: ____________________

Cell Phone: ____________________

Other Phone: ____________________

Please include ALL phone numbers in which you can be reached for appointment information.

Email: ____________________

Is the patient currently receiving **Home Health Care** or any other assistance in the home? (e.g., Thompson Home Health, Companion Care, etc.).

☐ Yes; Name of Agency: ____________________ ☐ No

What is the reason for the visit today?

Primary Insurance:
I.D. #
Group #
Phone #

Secondary Insurance:
I.D. #
Group #
Phone #

Emergency Contact:

Phone #

Referred by:

Primary Care Physician:

Operations and/or Other Medical Procedure (**Please Include Dates**):

Please List Current Medications:

Allergies to Any Medications:

Describe Any Major Accidents: (**Please Include Dates**):

Accident Event(s)	Date

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MEDICAL HISTORY:
Please Mark "X" Below and Provide Approximate Ages
at Which the Patient Suffered the Following Illnesses and Conditions

Condition	Mark "X"	Age
Adenoidectomy		
Chicken Pox		
Croup		
Ear Infections		
Headaches		
Influenza		
Meningitis		
Otosclerosis		
Sinusitis		
Tonsillitis		
Allergies		
Colds		
Dizziness		
Encephalitis		
Other:		
Other:		
Other:		

Condition	Mark "X"	Age
Mumps		
Pneumonia		
Tinnitus		
Asthma		
Convulsions		
Draining Ear		
German Measles		
High Fever		
Measles		
Noise Exposure		
Seizures		
Tonsillectomy		
Mastoiditis		
Hearing Loss		
Other:		
Other:		
Other:		

When was the patient's last physician/medical visit for this problem?

When is the patient's next follow-up appointment for this problem?

Has the patient seen any other specialists (physicians, psychologists, neurologists, etc.)? If YES, indicate the type of specialist, when the patient was seen, and the specialist's conclusions or suggestions.

Type of Specialist	Date Seen	Conclusion/Suggestions/Results

SPEECH-LANGUAGE-COGNITIVE-SWALLOW HISTORY:

Who lives in the home?

What languages do you speak? If more than one, which one is your primary language?

What was the highest grade, diploma, or degree earned?

Describe the patient's speech-language-cognitive-swallow problem.

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Has the patient seen any other speech-language pathologists? If YES, please describe below.

☐ YES ☐ NO

Speech-Language Pathologist	Date Seen	Conclusion/Suggestions/Results

Are there any other speech, language, cognitive, swallow, learning, or hearing problems **in your family**? If YES, please describe below.

☐ YES ☐ NO

Disorders / Conditions	Date Diagnosed	Describe: (Who in the family? Description of Problem)
Speech Disorder / Delay		
Language Disorder / Delay		
Cognitive Disorder		
Swallow Disorder		
Learning Disorder / Disability		
Hearing Problems		
Other:		
Other:		

Does the patient have any eating or swallowing difficulties? If YES, please describe below.

☐ YES ☐ NO

Provide any additional information that might be helpful in the evaluation or remediation process.