ST LUKE'S NORTH
SPEECH PATHOLOGY SERVICES
ADULT INTAKE FORM

DATE OF REFERRAL _____

PATIENT NAME _____ DOB _____

ADDRESS _____

_____

HOME PHONE _____ PHYSICIAN _____

WORK PHONE _____

DOMINANT LANG _____

REASON FOR REFERRAL

☐ SWALLOWING ☐ Coughing/Choking ☐ Recent weight loss

Current Diet: _____

VBSS yes no where? _____

☐ CVA (stroke) difficulty understanding? difficulty speaking?

CVA date _____

☐ VOICE describe voice _____

☐ STUTTERING describe concerns _____

☐ COGNITIVE describe concerns _____

☐ DEMENTIA describe concerns _____

☐ TBI describe concerns _____

Other professionals seen? _____

ie - ENT, Neurologist, ETC

Therapy at other facilities? _____

Reports requested - Doctors _____

Reports requested - Therapy _____

Hearing status Within normal limits Aided

Medical complications _____

_____

Insurance _____

Eval date _____ packet complete date _____

Time _____ last hearing test _____

Therapist _____ script? _____