Adult Speech & Cognitive Therapy Intake Form

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1. Patient Information

- **Patient Name:** _____
- **Date of Birth:** ____ / ____ / ____
- **Current Residence:** (e.g., Private Home, Assisted Living, Memory Care)
- **Primary Caregiver/Contact Name:** _____
- **Relationship to Patient:** _____

2. Medical History

- **Primary Diagnosis:** _____
- **Date of Onset (e.g., Date of Stroke/Injury):** ____ / ____ / ____
- **Other Relevant Conditions:** (Check all that apply)
  - [ ] High Blood Pressure
  - [ ] Diabetes
  - [ ] Hearing Loss (Left/Right/Both)
  - [ ] Vision Impairment
  - [ ] Previous Speech Therapy
- **Current Medications:** _____

3. Communication Concerns

- **Does the patient have difficulty with:** (Check all that apply)
  - [ ] Finding words
  - [ ] Slurred speech
  - [ ] Understanding conversation
  - [ ] Reading or writing
- **Primary Language spoken at home:** _____

4. Cognitive & Memory Concerns

- **Does the patient experience difficulty with:**
  - [ ] Short-term memory (e.g., forgetting names or appointments)
  - [ ] Problem-solving (e.g., managing bills or navigation)
  - [ ] Orientation (e.g., knowing the day or time)
  - [ ] Attention/Concentration

5. Swallowing & Feeding (Dysphagia)

- **Does the patient experience:**

    - [ ] Coughing or choking during meals
    - [ ] Difficulty chewing
    - [ ] Sensation of food "stuck" in throat
    - [ ] Frequent pneumonia or chest infections
- **Current Diet Texture:** (e.g., Regular, Mechanical Soft, Pureed)

6. Goals for Therapy

- **What is the primary goal for seeking therapy at this time?**

Privacy Statement: The information provided on this form is strictly confidential and will be used solely for clinical evaluation and treatment planning by Amy Walker, M.S., CCC-SLP.