BrightCove THERAPY CO.

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OFFICE USE ONLY	
ID	
DATE	
OTHER	

ADULT INTAKE FORM

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

- Speech-language evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations.
- 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 EARLIEST CONVENIENCE.

YOUR INFORMATION			
FULL NAME	GENDER ☐ Male ☐ Female		DOB
CURRENT AGE	EMPLOYED? ☐ Full-time ☐ Part-time ☐ Student ☐ None		MARRIED? ☐ Yes ☐ No
ADDRESS	CITY		ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL		
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT ☐ PHONE 1 ☐ PHONE 2 ☐ EMAIL		
PLACE OF EMPLOYMENT/SCHOOL	POSITION		
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.	
How do you react to your communication difficulty(s)?	☐ I try again/revise ☐ I become angry/frustrated ☐ Other: ☐ I give up ☐ I don't notice the problem
Why are you seeking speech-language services?	
Has your physician noticed your communication concerns? If yes, what were his/her recommendations?	
How did you learn about our services?	

In the table to the right, list other **therapeutic services** you have received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. ☐ None	TYPE OF SERVICE	DATES	NAME OF PROVIDER

FAMILY INFORMATION

With whom do you live? (Check all that apply)			
	☐ Spouse	☐ Parent(s)	☐ Children
	☐ Roommate(s)	☐ Alone	☐ Other:

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

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

SPOUSE/EMERGENCY CONTACT INFORMATION

FULL NAME		GENDER ☐ Male ☐ Female	DOB
ADDRESS		CITY	ZIP
PHONE 1	☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2	☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT	☐ PHONE 1 ☐ EMAIL ☐ PHONE 2
RELATIONSHIP TO YOU		MAY WE DISCUSS YOUR TREATMENT WITH THIS PERSON? ☐ Yes ☐ No	

Are there family circumstances that would be helpful to share with your therapist? (e.g., legal or safety requirements)	
Do you speak any other languages? If yes, which language(s) and how often?	

Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)	RELATION TO YOU	RELATED DIAGNOSIS/DISORDER

YOUR SOCIAL BACKGROUND			
Where have you **lived**? Include city/state/approximate ages.			
Describe your **childhood**, including any diagnoses, accidents, or communication difficulties.			
What is the highest level of **education** you completed? List any degrees.			
What types of **jobs** have you held in the past?			
Describe your **social life**. How many friends do you have; how often do you get together?			
Describe your **extended family**. List names and ages of your **children and grandchildren**.			
How do you usually communicate with others?	☐ Face-to-face ☐ Phone call	☐ Email ☐ Text message	☐ Video call (Skype, Facetime) ☐ Other:
How has your communication problem impacted your work and social life?			

YOUR HEALTH BACKGROUND		
Has your **hearing** been tested recently? ☐ Yes ☐ No	DATE	
	PLACE	
	RESULTS	
Describe any **serious illnesses**, injuries, or medical procedures you have experienced.		
List any environmental or food **allergies**.		
List any current **medications** and their purposes.		
Describe any other **conditions or diagnoses.**		
Describe any difficulties with **eating, swallowing, chewing**, textured foods, etc.		
FAVORITE FOODS	FOOD AVERSIONS	

Has your speech-language been evaluated before? If yes, when, where, and what were the findings?	
What do you hope to accomplish by participating in speech therapy?	
YOUR PERSONALITY	
Describe your strongest skills and personality traits. What makes you unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE STORES	
FAVORITE MOVIES	
FAVORITE BOOKS	

LIST ANY COMMENTS OR QUESTIONS FOR THE THERAPIST:

Thank you for taking the time to complete this information.

_____ _____

YOUR SIGNATURE DATE