Patient History – Adult

Name: ______________________________

Date of Birth: ______________ Age: ________ Sex: Male ☐ Female

Address: ______________________________

City: ______________ State: ________ Zip: ________

Home Phone: ______________________________

Cell Phone: ______________________________

Work or Other Phone: ______________________________

E-mail: ______________________________

Race/Ethnicity (select one or more):

☐ American Indian/Alaskan Indian ☐ Asian

☐ Black/African American ☐ Hispanic/Latino

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

Emergency Contact:

Name: ______________________________

Phone Number: ______________________________

Is this number for ☐ Home ☐ Cell ☐ Work

Relationship to Patient: ______________________________

Referral Source:

☐ Doctor ☐ School ☐ Counselor/Therapist ☐ Friend ☐ Self ☐ Other

Insurance Information:

Primary Insurance: ____________________

Policy Holder Name: ____________________

Group Number: ____________________

Phone Number: ____________________

Secondary Insurance: ____________________

Policy Holder Name: ____________________

Group Number: ____________________

Phone Number: ____________________

Reason for Visit Today

____

____

____

Have you received speech-language pathology services before? ☐ Yes ☐ No

If yes, when? ____________________

Where? ____________________

Medical History:

List illnesses, surgeries, injuries, or medical problems:

____

____

List medications taken on a regular basis:

____

____

List known allergies:

____

____

Have you had problems with or changes in (check all that apply):

☐ Hearing:

Wear hearing aid(s)? ☐ Yes ☐ No

Had hearing test? ☐ Yes ☐ No

If yes, when? ______________________________

☐ Vision:

Wear glasses? ☐ Yes ☐ No

Wear corrective lenses? ☐ Yes ☐ No

Had vision screened? ☐ Yes ☐ No

If yes, when? ______________________________

☐ Teeth:

Wear dentures? ☐ Yes ☐ No

☐ Breathing:

☐ Swallowing:

Education and Work History

Last grade completed: ______________________________

Occupation: ______________________________

Currently working? ☐ Yes ☐ No

Recreational Activities: ______________________________

Language(s) Spoken

Is English your primary language? ☐ Yes ☐ No

If no, is an interpreter needed? ☐ Yes ☐ No

If no, what language(s) is/are spoken at home:

____

If no, what language(s) is/are spoken in your workplace/community:

____

Additional Information

Is there anything else you'd like for us to know about you?

____

____

____

Patient or Parent/Guardian Signature

____

Relationship to Patient

____

Date