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