MidState Therapy Associates
Speech & Occupational Therapy For Children and Adults

SPEECH ADULT INTAKE

Client Name:	**Age:**		
Address:	**DOB:**	**Sex:**	
	City:	**State:**	**Zip:**
Phone:	**Cell:**		

Reason of referral:	
Referral source:	
Physician:	**Phone:**
Address:	
Specialist:	**Phone:**
Address:	
Surgeon:	**Phone:**
Address:	

Health/Medical Issues
Are you in good health? ☐ **Yes** ☐ **No** **If not, please describe:**
How long have you had this problem?
Do you have any allergies?
Do you have a history of ear infection?
When was your most recent hearing test?
Current medications

Please list any other important information regarding your child's medical status:

What do you expect from this evaluation?

300 Craig Road Suite 207 • Manalapan NJ, 07726 •732-431-5093• FAX 732-431- 5094
Website: www.midstatetherapy.com • Email: mtherapy1@optimum.net