



# MidState Therapy Associates

Speech & Occupational Therapy For Children and Adults

## SPEECH ADULT INTAKE

<b>Client Name:</b>	<b>Age:</b>		
<b>Address:</b>	<b>DOB:</b>	<b>Sex:</b>	
	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Phone:</b>	<b>Cell:</b>		

<b>Reason of referral:</b>	
<b>Referral source:</b>	
<b>Physician:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Specialist:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Surgeon:</b>	<b>Phone:</b>
<b>Address:</b>	

Health/Medical Issues
Are you in good health? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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What do you expect from this evaluation?

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