Let's Talk! Therapy Center Adult Intake Form

Today's Date: _____

Name of person completing this form: _____

Relationship to the Client: _____

Phone: _____

Patient's Name	SS #:
Address	Date Of Birth:
City, State, Zip	Home Phone:
Employer	Work Phone:
Email Address	Cell Phone:

Gender: (Please Circle): Male Female

Marital Status: (Please Circle): Single Married Divorced Widowed

Spouse's Name:	SS #:
Address (if not the same:	Date Of Birth:
City, State, Zip	Home Phone:
Employer	Work Phone:
Email Address	Cell Phone:

List Names of others living in the home: _____

Are you currently receiving home assistance? Yes No If yes, how often? _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Insurance

Insurance Carrier: _____ Name on Card: _____

DOB: _____ Contract Number: _____ Group Number: _____

Secondary Insurance

Insurance Carrier: _____ Name on Card: _____

DOB: _____ Contract Number: _____ Group Number: _____

LET'S TALK!
THERAPY CENTER

Preferred Phone Number to Contact: _____

Would you like to receive a courtesy reminder call for every scheduled appointment? (Please Circle) Yes No

Please Circle if you have been diagnosed with any of the following:

Allergies	PEG Tube	Degenerative Disease
Pnemonia	Cancer	Cognitive Impairment
Cleft Palate	Auto Accident (date) _____	Asthma
Stroke/TIA	Head Injury (Date) _____	Hearing Loss
Problems Swallowing	Respiratory Problems	Depression/ Mental Illness
Chronic Colds	Ear Infection	Seizures/ Epilepsy
Chronic Cough	Developmental Delay	A.D.D

Please describe any birth injury or diagnosed abnormality:

Have you ever been referred to any of the following specialists? (Please circle)

Audiologist	Otolaryngologist (ENT)	Gastroenterologist
Psychologist	Psychiatrist	Occupational Therapist
Physical Therapist	Speech Therapist	

If yes, please state the reason and results: _____
_____

Test (s) Completed (Please ciricle). MRI CT Scan Chest X-Ray Other: _____

Have there been any Hospitalizations? (Please Circle) Yes No If yes, describe and use dates: _____
_____

Please list any medications you are currently taking (prescription and non-precription): _____
_____

Physician's Name: _____ Physician's Phone #: _____

Please circle your answer:

Do you smoke?	Yes	No	If yes, how much per day? _____
Do you have a history of smoking?	Yes	No	If yes, for how long? _____
Do you drink alcohol?	Yes	No	If yes, how much? _____

Primary Language: _____ Are you currently driving? (Please circle): Yes No

Educational History:
Highest Grade Completed: _____ Degree(s) Obtained: _____ Name of Institution: _____

Have you ever had difficulty with any of the following during your educational years? (Please circle)
Understanding Reading Speaking Writing Attention Memory Problem Solving

Work History:
Are you currently employed? Yes No Occupation: _____
Job Duties: _____

Social History:
Employment/ Work/ School: (Please Circle)
Full-Time Part-Time Retired Student Unemployed Sports/Hobbies: _____

What are your household responsibilities? (Circle all that apply):

Computer Tasks	Household	Yard Work	Cleaning
Child Care	Repairs	Cooking	Driving
Balancing	Grocery	Laundry	
Checkbook	Shopping		

Therapy History:

List any therapy you have received (include when, where, and duration):_____
_____

What information do you hope to obtain from this evaluation? _____
_____
_
Is there any other important information that you feel may be helpful to your treatment? _____
_____

Please list any questions you would like answered: _____
_____

Who referred you to Let's Talk! Therapy Center? _____

Who will be responsible for payment of therapy services? _____

Your Signature: _____ Date: _____