



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):

- | | |
|--|---|
| <input type="checkbox"/> American Indian/Alaskan Indian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> White <input type="checkbox"/> 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

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