Patient Information and Intake

- **Name**
  Last name: Middle name: First name:
- **Demographics**
  DOB: Age: Pronouns:
  Languages spoken: Interpreter? Yes No
- **Email Address:** ____
- **Address**
  Street: City: State:
  Zip:
- **Phone Numbers**
  Home: Cell: Work/other:
- **Further Info**
  Emergency contact name/number: SLP eval date:
  Admission date:
- **Referring Physician or Service:**
- **Clinician Information**
  Clinician ID: Clinician NPI number:
- **Primary Funding Source**
  Medicare A Medicare B Medicaid (fee for service)
  Medicaid (Managed) Veterans Administration Managed care plan
  Self-pay Unknown

  Insurance name: Insurance ID#: Name of insured:
- **Diagnoses**
  Primary medical: Secondary medical:
  Communication/swallowing disorder:
- **Treatment Settings**
  Current: Previous:

Templates are consensus-based and are provided as a resource for members of the American Speech-Language-Hearing Association (ASHA). Information included in these templates does not represent official ASHA policy.

- **Received SLP Services in Previous Setting**

Yes	No	Unknown

- **Living Situation**

Home alone	Home with other:	Skilled nursing facility
Assisted living	Homeless	Unknown
Other		

- **Occupation**

Current: Previous:

- **Educational Background**

Non-HS grad	HS grad/GED	College grad
Advanced degree	Currently attending:	Unknown

- **Cultural/Linguistic Considerations:**

____
____

- **Reason for Referral**

AAC	Cognitive communication	Language
Resonance	Speech	Swallowing
Voice		

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