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