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NEW HORIZONS WELLNESS SERVICES, LLC
Empowered from Within

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Adult Speech Intake Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the following important background information. If you do not understand a question, leave it blank and your therapist will assist you in answering it. Thank you.

PATIENT INFORMATION

Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: □ M □ F

Who referred you to NHWS? _____

Reason for referral? _____

MEDICAL HISTORY

Please list any hospitalizations or surgeries:

Do you have any medical diagnoses? Are you on any medications?

Is there a family history of speech and/or language delays or learning disabilities?

Is there any other pertinent medical or family history?

Have you had any prior evaluations or therapy to address your speech? If so, where?

Do you have any difficulties with your hearing?

SPEECH-LANGUAGE HISTORY

Symptom	Never	Sometimes	Frequently
Difficulty Swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Problem solving			
Focusing/attention			
Reading/writing			
Finding words			
Maintaining topic of conversation			
Fluent speech (stuttering)			
Following directions			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc..)			
Voice difficulties			

Please describe your current speech problem:
What do you think caused your speech problem?
What conditions seem to make the problem better or worse?
How does speech affect your job or other aspects of your life that require communication? Please explain.
What strategies have you used at home to work on this problem?

I certify that the information on this form is correct to the best of my knowledge. I will not hold my therapist, NHWS, or NHWS staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____