7145 Turner Road, Suite 101 Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

Adult Intake Form

Name:_____ Birth date_____

Age_____ Gender M F Phone(s)_____

Address_____

City_____ State_____ Zip_____

Email _____

I do wish to allow email communication _____

I DO NOT wish to allow email communication _____

Reason for referral _____

Insurance Information

Insured's Name (if different from patient)_____

Relationship to patient _____ Insured's DOB _____

Insurance_____

Group #_____ ID# or SS# _____

Insurance phone# _____

Referred by_____

Doctor's Name _____

Doctor's Address _____ Doctor's Phone _____

Last doctor visit _____

Health History

Have you received any physical therapy this year? Yes/No _____

If yes, please explain _____

Please mark if you have any of the following: _____ atrial fibrillation

_____ Seizures _____ chronic colds _____ pacemaker _____ pneumonia

_____ diabetes _____ heart attack _____ asthma _____ COPD

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Any other serious or recurrent illnesses? _____

Current general health _____

Current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hearing difficulties _____ hearing aids _____

Vision difficulties _____ glasses/contacts _____

Dental problems _____ treatment _____

Other _____

Ongoing medical care _____

Chronic health problems _____

Any speech or hearing problems in family? _____

Other languages spoken in home? _____

What are your communication needs in social settings? _____

_____

What are your communication needs in work setting? _____

_____

What difficulties do you have meeting your communication needs? _____

_____

Educational History

Highest education level (circle one): High School some college bachelors masters

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Does communication affect your performance in school? _____

On the job? _____ plans for the future? _____

Hobbies _____

Social groups to which you belong _____

Other info you would like us to know _____

_____

_____

PLEASE READ AND SIGN THE FOLLOWING

I give permission for Speech Path of Brevard, LLC and contracted therapists to evaluate and treat me.

Signature _____ Date _____

I have reviewed and received Speech Path of Brevard LLC's HIPAA Policy Statement.

Signature _____ Date _____

I authorize release of any medical or other information necessary to process this claim, including release of information to my Primary Care Physician as designated above and directly to the insurance company. I authorize payment of medical benefits to Speech Path of Brevard, LLC for services provided. I request and assign benefits to Speech Path of Brevard, LLC for all insurance benefits otherwise payable to me for services rendered.

Signature _____ Date _____

I authorize discussion of my case with the following specific individuals

_____

_____

Signature_____ Date _____