NEW PATIENT INFORMATION: ADULT
HEADWAY REHABILITATION

Last Name	First Name	DOB

Street Address

City	State	Zip Code

Home Phone	Cell Phone	Email Address

Primary Doctor Full Name	Referring Doctor Full Name (if none, please list how you heard about us)

Marital Status	Sex	Employment	Student
Married ☐ Widowed ☐ Divorced ☐ Single ☐ Separated ☐	Male ☐ Female ☐	Retired ☐ None ☐ Full ☐ Part ☐	Full ☐ Part ☐ None ☐

Employer Name	Business Phone

Employer Street Address

City	State	Zip Code

EMERGENCY CONTACT

Last Name	First Name	Relationship to Patient

Home Phone Number	Cell Phone Number	Work Phone Number

1. List your children, if any (include names, gender, and ages):

2. List who lives at home with you:

3. Are languages other than English spoken in your home? ☐ Yes ☐ No
   If yes, please list:

4. What was the highest grade, diploma, or degree you earned?

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5. Describe your speech-language problem:

6. What do you think caused the problem?

7. Has the problem changed since it was first noticed? ☐ Yes ☐ No

If yes, please describe:

8. Have you been evaluated by any other professional? (Check all that apply)

☐speech-language pathologist (SLP) ☐audiologist

☐occupational therapist (OT) ☐neurologist

☐physical therapist (PT) ☐physician

☐psychologist/psychiatrist ☐other____

9. Do you have a diagnosis from any of the above professionals? ☐ Yes ☐ No

If yes, please list the date, professional, and diagnosis for each:

10. Have you received previous speech-language treatment? ☐ Yes ☐ No

If yes, please list the location(s) and describe the duration and outcome of the therapy:

11. Does anyone in your family history have a speech-language that you are aware of? ☐ Yes ☐ No

If yes, please describe:

12. Describe any major surgeries, operations, or hospitalizations (include dates):

13. Describe any major accidents (include dates):

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14. List medications taken on a regular basis:

15. Are you having any negative reactions to these medications? ☐ Yes ☐ No
    If yes, please describe:

16. List known allergies:

17. Have you had problems with or changes with your hearing? ☐ Yes ☐ No
    If yes, please describe:

    Do you wear hearing aid(s)? ☐ Yes ☐ No

18. Have you had problems with or changes with your vision? ☐ Yes ☐ No
    If yes, please describe:

    Do you wear glasses? ☐ Yes ☐ No

    Do you wear contact lenses? ☐ Yes ☐ No

19. Have you had problems with or changes with your breathing? ☐ Yes ☐ No
    If yes, please describe:

20. Have you had problems with or changes with your swallowing/eating? ☐ Yes ☐ No
    If yes, please describe:

21. Have you had problems with or changes with your teeth? ☐ Yes ☐ No
    If yes, please describe:

    Do you wear dentures? ☐ Yes ☐ No

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22. Please provide any additional information that might be helpful in the evaluation or remediation process:

23. What do you hope to gain from this evaluation?

24. Do you want these evaluation results sent to another professional? ☐ Yes ☐ No

If yes, please list below (include name, profession, and fax number):

1. ____

2. ____

3. ____

Person completing this form: ____

Relationship to patient: ____

Signature: ____ Date: ________________________________

Thank you for taking the time to fill out this form!

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