Glen Cove Hospital
Northwell Health℠

OUTPATIENT SPEECH AND LANGUAGE INTAKE FORM

Name: _____ Date of Birth: _____ Date: _____

Please answer the following questions to the best of your ability:

1. What problem brings you to speech and language therapy? (check all that apply and write in date diagnosed):
   - □ Stroke _____ □ TIA _____ □ Swallowing Difficulty _____
   - □ Traumatic Brain Injury _____ □ Aphasia _____
   - □ Dysarthria/Apraxia _____ □ Facial Weakness _____
   - □ Cancer: □ Head/Neck____ □ Jaw_____ □ Mouth____ □ Throat _____
   - □ Other: _____

Speech:

2. Have you had a speech and language evaluation at another clinic? □ No □ Yes
   - Name of clinic: _____
   - Address: _____
   - Date of evaluation: _____
3. Have you received previous Speech Therapy? □ No □ Yes
   - When? _____ Where? _____
   - For how long? _____ Therapist's Name: _____

4. What was the focus of your previous Speech Therapy? _____
   _____
   _____

5. Have you had any current: X-Rays? □ No □ Yes, Date _____ Where _____
   CT Scans? □ No □ Yes, Date _____ Where _____

6. What was your prior level of communication?
   - □ Independent □ Need assistance some of the time □ Maximum assistance to communicate

7. Current Level of Communication: I can express basic needs or wants: □ No
   - □ Yes: How: □ verbal □ writing □ single words □ sentences □ pointing/gestures

8. Who do you primarily communicate with?
   - □ Spouse □ Children □ Healthcare Worker □ Others: _____

9. Please list your hobbies/outside activities: _____

   _____

10. Do you still participate in your hobbies? □ No □ Yes _____

11. List Family Member names and relationship: _____

_____ _____ _____

_____ _____ _____

12. Please list your daily responsibilities prior to difficulty (ie: shopping, checkbook, laundry, cooking)

_____

_____

_____

Swallowing:

13. Have you ever been evaluated for a swallowing problem? □ No □ Yes
If yes, by whom? _____

What were the recommendations? _____

_____

14. Are you currently on a modified diet? □ No □ Yes
If Yes, what are the details of your diet modifications? _____

_____

15. What is your goal for Speech/Swallow Therapy? _____

_____

I certify the above information is true to the best of my knowledge and ability.

_____
Patient/Representative Print Name

_____ _____ _____
Patient/Representative Signature Relationship Date