Core Communication Center

Pediatric and Adult Speech Therapy

Intake Form - Adult

Current Date:

Patient Information

Male Female

Last Name: First Name: Birth Date:

Address *(residence)*: Apt. #: Address *(mailing)*:

City: State: Zip:

Email: Phone: cell home work

Primary Care Physician:

Emergency Contact: Phone:

Referral Information

Referred by: Phone:

Relationship to patient:

Health History

Medical Diagnosis:

Operations, Accidents, Illnesses:

Allergies:

Medication List: *Please list medication and what it is for.*

Do you wear: Hearing Aides Glasses Dentures

222 Tuckerman Road, Ashburnham, MA 01430
Phone: (978) 833-1887 ***Fax:*** (978) 252-5218
CoreCommunciationCenter@gmail.com

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Pediatric and Adult Speech Therapy

How Can We Help

Have you ever had Speech Therapy? ○ No ○ Yes

Where: _____ When: _____

Reason: _____

Please describe why you are here today, and what your concerns are.

_____

What are your symptoms: _____

When are symptoms at their worst: _____

How do you compensate for your problem: _____

How can we help you?

_____

Office Use Only I Initial Contact _____

Diagnosis Code: _____

_____

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