Mankato Clinic

Patient Name:
DOB:
Date:

INTAKE QUESTIONNAIRE

Person completing this form: _____

What problem brings you here today? _____

How long have you been experiencing this problem? _____

Please list any medical diagnoses: _____

Allergies/Precautions/Restrictions: _____

_____

Current/regular medications: _____

_____

Have you had medical testing (MRI, EKG, etc.)? If so, please list: _____

_____

What is your highest education level? (Please circle)

Middle School High School Some College College degree

Where do you reside at this time? (Please circle)

Home-Independent Home with assistance Assisted Living Facility

Group Home Skilled Nursing Facility Other: _____

Please indicate if you have a history of any of the following:

	Yes	No		Yes	No
Frequent colds, respiratory infections, pneumonia?			Do you suffer from reflux?		
Any serious illness or injury?			Have you had speech therapy before?		
Do you wear eye glasses and/or corrective lenses?			History of seizures?		
Do you wear dentures?			Are you employed? What is your profession?		
Have you had your hearing evaluated? When?			Have you had your swallowing evaluated?		
Do you wear hearing aids?			Are you on a modified diet?		
Do you consume alcohol? If yes, how many drinks per week?			Do you use tobacco? If yes, how much per day?		

Please list 3 goals you would like to see accomplished through speech therapy:

1) _____
2) _____
3) _____