

HUNTER COLLEGE CENTER
FOR COMMUNICATION DISORDERS
ADULT PRE-INTAKE HISTORY

Scheduled Date of Evaluation: _____

Clinician: _____

Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Phone: _____ Marital Status: _____

Occupation: _____ Education: _____

Referred by: _____

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How would you describe your problem? _____

Does the problem vary, being better or worse at certain times? _____

Please describe: _____

Did this begin gradually or suddenly? _____

What do you think was the cause(s)? _____

Does anyone else in your family have a similar problem? Is so, please describe: _____

Has, or does, this problem interface with your schooling and/or your job performance? If so, in what way? _____

Have you received any previous medical or therapeutic services for this problem? If so, please provide the type of service, date and name of the consultant:

Type of Service	Consultant & Address	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medical problems you have (include any medication taken on a regular basis): _____

What questions do you want answered by this evaluation? _____

Additional information may be added here: