Mercer Health
Therapy & Rehabilitation

LABEL

Form 505

New Patient Intake Form

Speech Therapy

Name: _____ DOB:_____

PERSONAL

Do you speak and read English easily? ☐ Yes ☐ No

If no, what language do you use daily? _____

HISTORY OF CURRENT COMPLAINT

What is the reason for coming to therapy? _____

How did this happen? (accident, etc.) _____

When did it start? _____Have you had this problem before? ☐ Yes ☐ No

Have you had therapy for this problem before? ☐ Yes ☐ No

If yes, when? _____ At what facility? _____ How long? _____

Has your doctor run any of the following tests for your current problem?

☐ MRI ☐ CT ☐ Swallowing Study ☐ Other: _____

Females Only: Is there any chance you might be pregnant? ☐ Yes ☐ No

Are you currently having any pain or have you had pain in the recent past? ☐ Yes ☐ No

What do you hope to get out of speech-language therapy? _____

_____

Are you currently working: ☐ Yes ☐ No If so, what is your job: _____

Do you feel that this condition affects your working ability: ☐ Yes ☐ No

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MEDICAL HISTORY

Have you had, or do you now have, any of the following listed conditions? (Check all that apply)

- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Panic Attacks
- ☐ Stroke
- ☐ Diabetes
- ☐ Gland Problems (Thyroid)
- ☐ Arthritis
- ☐ Anxiety
- ☐ Cancer: _____
- ☐ Drink Alcohol: ☐ None ☐ Occasionally ☐ Often
- ☐ Lung Disease
- ☐ Circulation Problems
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Stomach Problems
- ☐ Seizures
- ☐ Blood Disorder
- ☐ Depression
- ☐ Kidney/Bladder Control
- ☐ Asthma
- ☐ Emphysema
- ☐ Current Smoker
- ☐ Breathing Problems
- ☐ Pneumonia
- ☐ Parkinson's Disease
- ☐ Huntington's Disease
- ☐ Acid Reflux
- ☐ Vocal Polyups/Nodules
- ☐ Head Injury/TBI

☐ Other Not Listed (please explain): _____

☐ Allergies – Please List: _____

Please list any prior surgeries and dates: _____

_____

Please list any hospitalizations over the last 2 years, the reasons and dates: _____

_____

Are there any additional issues or concerns that you would like your therapist to be aware of? _____

_____

Next Referring Doctor's Appointment: _____

Person completing this form: _____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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SPEECH-LANGUAGE HISTORY

SYMPTOM	NEVER	SOMETIMES	FREQUENTLY
Difficulty Swallowing	☐	☐	☐
Difficulty Expressing thoughts	☐	☐	☐
Difficulty being understood by others	☐	☐	☐
Difficulty understanding others	☐	☐	☐
Orientation	☐	☐	☐
Memory	☐	☐	☐
Problem Solving	☐	☐	☐
Focusing/attention	☐	☐	☐
Reading/writing	☐	☐	☐
Finding Words	☐	☐	☐
Maintaining topic in Conversation	☐	☐	☐
Fluent Speech (stuttering)	☐	☐	☐
Following Directions	☐	☐	☐
Oral Motor Weakness (tongue, lips, etc)	☐	☐	☐
Voice Difficulties	☐	☐	☐

Are there any other difficulties besides what is listed above? _____

_____

Did the problem begin suddenly or develop over time? _____

_____

Does this speech-language difficulty impact your ability to function in daily life? How? _____

_____

Describe your daily communication needs: _____

_____

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Informed Consent for Physical, Occupational and Speech Therapy

I consent to receive Physical, Occupational, and/or Speech Therapy services as recommended by my provider. I understand the nature and purpose of these services, including potential benefits and risks. I acknowledge that no guarantees have been made regarding outcomes. I understand I may ask questions and may withdraw consent at any time.

I authorize the therapist and staff to provide evaluation and treatment as deemed appropriate.

Insurance: As a courtesy, we have contacted your insurance company to verify your therapy benefits and will follow your plan's guidelines. However, we cannot guarantee payment for services rendered. We recommend contacting your insurance provider directly for a complete explanation of your benefits and coverage. The patient is ultimately responsible for payment for services rendered.

_____ _____

Signature of Patient/Legal Guardian **Date**

I hereby certify that I have explained the proposed evaluation and treatment. I have offered to answer questions. I believe that the patient/guardian understands what I have explained and answered.

_____ _____

Therapist Signature **Date**

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Medical Information Release

In order for our staff to discuss your medical care (or your child's medical care) with someone other than yourself (including a spouse or other family member) we must have your consent. If you know of anyone that may be requesting your (or your child's) medical information from our office (not including another physician or clinic) please give your consent below. By signing this you are releasing the staff of Mercer Health from any and all liability for fulfilling this authorization request.

I hereby authorize the staff of Mercer Health to disclose information related to my (or my child's) current episode of care to the person's listed below:

Name_____Relationship _____ Telephone_____

Name_____Relationship _____ Telephone_____

Name_____Relationship _____ Telephone_____

This authorization will expire upon me (or my child) being discharged from this episode of care.

_____ _____
Name of Patient (Printed) Date of Birth

_____ _____
Name of Parent/Legal Guardian, if applicable (Printed) Relationship to Patient

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Witness Date

Authorization is valid from the date of signature or until we receive written notification from you. I understand that I may revoke this authorization in writing at any time.

Date Revoked: _____ Signature: _____
Patient or Parent/Legal Guardian

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No Show Policy

To ensure all patients have access to needed therapy services, regular attendance is required. A "No-Show" is defined as missing an appointment or canceling within 2 hours of the scheduled time.

Exceptions may be made by the Office Manager for special circumstances (e.g., illness, hospitalization, weather).

- Patients with more than two No-Shows during their therapy plan will be discharged and will need a new physician order to resume services on the third No-Show. They will be placed on a waiting list once the new order is received.

Questions regarding this policy should be directed to the Office Manager.

Patient Signature: _____ Date: _____

Representative Signature: _____Relationship: _____

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