



## Adult Intake Form

### 1. Patient Information

Patient Name / Pronouns:

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DOB:

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Best Email:

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Best Phone:

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Referred By:

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Referring Provider & Reason for Referral:

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Primary Care Provider (name/practice):

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Patient Profession:

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### 2. Problem Areas (check all that apply)

- ☐ Breathing: Nose / Mouth / Chronic congestion / Allergies / Asthma / Loss of breath / Over breathing / Breathing while speaking challenging:

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- ☐ Sleeping: Sleep quality / Obstructive sleep apnea OSA / UARS / Snoring / Mouth breathing / Sleep separately:

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- ☐ Eating: Oral hygiene / Clearing teeth / Teeth / Strong gag / Swallowing / Choking / Digestion / Tongue-tied / Prolonged orthodontia:

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☐ Talking: Speech / Articulation / Mumbled / Voice / Fluency / Stuttering:

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☐ Feeling: Ears / Posture / TMJ dysfunction / Pain/tension face/neck/shoulders / Anxious / ADHD / ADD / Memory / Mental health:

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☐ Other:

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### 3. Medical History

ENT consults & diagnosis (date, findings):

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Sleep study results:

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Family history of related issues:

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Medications (can provide list or photo):

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Supplements:

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Surgeries (type/date):

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Accidents, hospitalizations, illnesses:

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Specialists seen (circle all that apply): Audiologist / PT / SLP / OT / Psych / ENT / TMJ / Ortho / Nutritionist / Naturopath / Allergist / Other: \_\_\_\_\_

Specialists names & dates:

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## 4. Dental & Oral Health

Dentist name & practice: \_\_\_\_\_

Current oral hygiene habits/tools: \_\_\_\_\_

Circle all the apply: TMJ Dysfunction / Grinding / Clenching / Excessive cavities / Prolonged Orthodontia

/ Oral appliances / Gum disease / Halitosis

Describe pain/discomfort:

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## 5. Speech, Voice & Social

Speech description: Clear / Mumbled / Slurred / Stuttering / Mouth breathing / Hypernasal / Hyponasal / Loud /

Quiet / Other: \_\_\_\_\_

Social: Interacts well / Anxious / ADD / ADHD / Prefers alone / Social communication differences (ASD, Aspergers, ODD)

Academic/Work performance: Poor / Average / Above average / Learning disability / Reading issues / Math issues

## 6. Coordinated Care

List all doctors/clinicians in your coordinated care team (dentist, PCP, ortho, etc.):

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☐ I authorize communication with my coordinated care team.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_