REACH FOR SPEECH
& BEYOND, LLC

Please print, fill out this form and bring it to your first appointment.

Name: _____ **DOB:** _____

ADULT INTAKE FORM

	YES	NO	Don't Know
Do you usually breathe through your mouth (lips apart)?			
Do you snore while sleeping?			
Do you toss and turn and/or sleep in strange positions when sleeping?			
Do you easily get tired or fall asleep during the day?			
Do you use sleep medication?			
Do you typically sleep through the night?			
Do you have any facial pain?			
Do you experience enuresis (bedwetting)/or getting up multiple times a night to urinate?			
Do you have difficulty opening or closing your mouth or while chewing?			
Do you clench or grind your teeth during the day? Night?			
Do you hyperextend your neck/head?			
Do your gums bleed?			
Is your pillow wet in the morning (drooling)?			
Do you keep your mouth open while watching TV or using the computer/iPad?			
Do you easily catch colds? Sinus infections? Allergies?			
Do you have a history of thumb/finger/tongue sucking? Bite nails?			
Do you have difficulty pronouncing sounds?			

Typically, how many hours of sleep do you get nightly? _____

What do you hope to achieve from this evaluation?

_____

_____

Describe the problem you're currently experiencing.

_____

_____

What do you think caused the problem?

_____

_____

What have you tried to fix the problem?

_____

_____

Thank you and see you soon!