New Client Intake Form

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| Child’s Name: | Nickname (if applicable): |
| Date of Birth: | DIAGNOSIS |
| Parent’s/caregiver’s names: | SIGNFICANT MEDICAL HISTORY: |
| Address:   |  | | --- | |  | |  | |  | | PHYSICIAN:  PHONE#: |
| Phone number: | MEDICATION: |
| E-mail: | MEDICAID NUMBER: |
| Receiving any other Therapy Services?  Scheduling of Services: | INSURANCE:  POLICY NUMBER:  PERSON RESPONSIBLE FOR INSURANCE: |
| ALLERGies:  Precautions: | Has the Child had speech before?   * Yes * No |
| Who Referred you? | Additional information: |