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OFFICE USE ONLY	
ID	
DATE	
OTHER	

SLP INTAKE FORM

CLIENT'S INFORMATION			
FULL NAME		GENDER ☐ Male ☐ Female	DOB
CURRENT AGE	SCHOOL/GRADE		JOB
PARENT/GUARDIAN NAME		CLIENT/PARENT/GUARDIAN PHONE	
CLIENT/PARENT EMAIL		CONTACT DATE(S)	
CLIENT/PARENT/LEGAL GUARDIAN CONCERNS Why are you currently seeking therapy When the problem began Who noticed it Where the problem occurs			
CLIENT CASE HISTORY (diagnoses, medications, salient medical and mental health history, history of other services)			
PHYSICIAN CONCERNS			
OTHER SERVICES AND EVALUATIONS ☐ None	TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER
REFERRAL SOURCE			
PLAN FOR FOLLOW UP			

____ _____________________
SPEECH-LANGUAGE PATHOLOGIST SIGNATURE DATE