SCHIEFELBUSCH SPEECH-LANGUAGE-HEARING CLINIC

Intake Questionnaire Today's Date ____________

Name____ Phone__________________

Mail Address____
Street City State Zip Code

Date of Birth________________________________ Email ____________________________________
MM DD YY

Parent or Guardian____
Name Phone Number

Referral Source____
Name Phone Number

Primary Care Physician____
Name Phone Number

Insurance____
Company Name Phone Number

____
Street City State Zip Code

____
ID # Group #

Prior Approval needed? _______ yes _______ no Phone Number for PA_____________________________

Name, as it appears on insurance card ____

To be seen for assessment ______ or intervention only ______

Reason for assessment or intervention ____

____

Forms sent: _____ Child Case History
_____ Adult Case History
_____ Reading Addendum
_____ Voice Case History
_____ Neurological Case History
_____ Dysfluency Case History
_____ Head Injury Case History
_____ ALS/AAC MDA ALSA

Appointment Made _____ yes _____ no

Appointment Date ___________________________

Intake Questionnaire give to __________________

Other pertinent information ____

____

____

CONTACT SHEET

Client Name: ____

Date (MM/DD/YY)	Writer's Initials	Record of pertinent information, i.e. phone calls, personal contact, observations, etc. regarding this client.