Speech Therapy New Patient Intake Form

Patient Information

First Name

Last Name

Date of Birth

Gender

Phone Number

Email

Home Address

Parent/Guardian Information (if patient is a child)

Parent/Guardian Name

Relationship

Phone Number

Email

Referral Information

How did you hear about us?

Referring Physician (if applicable)

Reason for Visit

Please describe the concern(s) regarding speech/language/hearing.

Medical History

Past or current medical conditions

Medications

Allergies

Developmental History (for children)

Significant birth or developmental history

Languages spoken at home

Previous therapy or interventions