Articulation Disorder Therapy Intake Form

Client Information

Client Name

Date of Birth

Age

Parent/Guardian Name

Address

Phone Number

Email Address

Medical & Developmental History

Relevant Medical History

Comments on Early Developmental Milestones

Hearing/Vision Concerns

Speech & Language

Describe Speech Concerns

When Were the Difficulties First Noticed?

Previous Speech Therapy (if any)

Languages Spoken at Home

Family History of Speech/Language Difficulties

Additional Information

Other Concerns/Goals for Therapy

How Did You Hear About Us?

Date

Signature