Cleft Palate Speech Therapy Intake Form

Patient Information

First Name

Last Name

Date of Birth

Age

Gender

Address

Parent/Guardian Name

Contact Number

Email

Medical & Surgical History

Type of Cleft

Surgical History (Type & Date)

Other Medical Conditions

Speech & Language Concerns

Primary Concern

Previous Speech Therapy (When, Where, Duration, Outcome)

Describe Current Speech (If known)

Languages Spoken at Home

Feeding, Hearing & Development

Any Feeding Issues?

History of Hearing Assessment/Results

Developmental Milestones/Delays

Other Information

Additional Information or Comments