Telehealth Speech Therapy Intake Questionnaire

Client Information

Full Name Date of Birth Phone Number

Email Address

Preferred Language

Parent/Guardian Information (if applicable)

Name Relationship to Client Phone Number

Email

Reason for Referral

Please describe the primary concerns When did you first notice these concerns?

Has the client received speech therapy before? If yes, please provide details

Medical & Developmental History

Medical diagnoses (if any) Medication(s)

Hearing/Vision challenges? Developmental milestones (walking, talking, etc.)

Communication Skills

Primary way of communicating Any difficulties with:

☐ Speaking ☐ Understanding ☐ Reading ☐ Writing ☐ Voice ☐ Stuttering

Other communication details

Educational/Work Information

Current school/employer Grade or occupation

Special education or support services?

Telehealth Access

Do you have access to a computer or tablet with internet? Preferred platform (Zoom, Google Meet, etc.) Any additional accommodations needed?

Additional Notes

Is there anything else you would like us to know?