Bird Kern Dalmia

Speech/Language Pathologists & Occupational Therapist

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SCREENING INTAKE FORM

CLIENT'S NAME:_____ **M** ◉ **F** ○

DATE OF BIRTH:_____

PARENT/GUARDIAN/SPOUSE_____

ADDRESS:_____

PHONE NUMBERS: (CELL)_____

(CELL)_____

EMAIL ADDRESS: _____

SECOND EMAIL: _____

SCHOOL DISTRICT:_____

PHYSICIAN: _____

TYPE OF INSURANCE: _____

WE DO NOT TAKE: MEDICAL, COVERED CA OR HMO

MEDICAL ID(INSURANCE) _____

REFERRED BY:_____

LANGUAGE(S) SPOKEN IN THE HOME:_____

_____

DESCRIPTION OF CONCERNS: (BRIEF)

_____

_____

_____

_____

OUTSIDE EVALUATIONS/DIAGNOSIS

_____

_____

_____

_____

HISTORY OF PREVIOUS THERAPY

_____

_____

_____

OTHER PROFESSIONALS WORKING WITH CLIENT:

_____

_____

_____

_____

AVAILABILITY: (DAYS/TIMES PREFERRED FOR WEEKLY THERAPY)

_____

_____

_____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

DATE THIS FORM WAS COMPLETED:_____

PERSON(S) FILLING OUT FORM:

_____

_____