Bird Kern Dalmia

Speech/Language Pathologists & Occupational Therapists

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SCREENING INTAKE FORM

CLIENT'S NAME:_____ **M**☐ **F**☐ **(check one)**

DATE OF BIRTH:_____

PARENT/GUARDIAN/SPOUSE_____

ADDRESS:_____

PHONE NUMBERS: (CELL)_____ **(CELL)** _____

EMAIL ADDRESS: _____

SECOND EMAIL: _____

PHYSICIAN: _____

TYPE OF INSURANCE: _____

NOTE: We are not providers for MediCal or Covered California

REFERRED BY:_____

LANGUAGE(S) SPOKEN IN THE HOME:_____

DESCRIPTION OF CONCERNS, SPEECH AND/OR OT:

_____

_____

_____

_____

_____

_____

_____

_____

_____

OUTSIDE EVALUATIONS/DIAGNOSES:

_____

_____

_____

_____

HISTORY OF PREVIOUS THERAPY:

_____

_____

_____

_____

OTHER PROFESSIONALS WORKING WITH CLIENT:

_____

_____

_____

DAYS/TIMES AVAILABLE FOR WEEKLY THERAPY (same for each session):

_____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

PERSON(S) FILLING OUT FORM:

_____ **DATE:**_____