



Bird Kern and 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:
