Cornerstone Speech & Language

2640 Highway 70, Suite 101B, Manasquan NJ 08736

INTAKE FORM

For initial speech & language evaluation

Client Name:_____ Date of Birth:_____

Parents' Names (if client is child): _____

Telephone:_____(home) _____(cell)

Address:_____City:_____ Zip_____

Email:_____
For our monthly newsletter and only used internally.

Physician:_____

How did you hear about Cornerstone Speech?_____

MEDICAL HISTORY

Significant medical issues/illnesses/hospitalizations? If yes, please explain._____

_____

_____

History of stomach problems?_____

Difficulty eating neatly?_____

History of ear infections? Tubes in the ears?_____

_____

Diagnosed disabilities?_____

Allergies?_____

Medications? If yes, what medications and for what purpose?_____

_____

Does anyone else in the family have a history of speech or language difficulties?

_____

REASON FOR THE EVALUATION

Please explain why you are concerned and what you want to find out from an evaluation._____

_____

_____

_____

Please explain any other concerns you have._____

_____

_____

For Children Only:
SCHOOL PERFORMANCE:

What school does your child attend?_____Grade_____

Does your child receive extra services at school? _____If so, what specific services?

_____

_____

How does your child do academically at school?_____

_____

How does your child do socially at school?_____

_____

What subjects are easy for your child? Why?_____

_____

What subjects are difficult for your child? Why?_____

_____

What are your concerns about your child's functioning at school?_____

_____

INSURANCE

Insurance Company_____

Policy Holder's Name_____

Policy Holder's Date of Birth:_____

Policy Holder's Employer:_____

ID Number on the Insurance Card:_____Group Number_____

PERMISSION TO VIDEOTAPE

I give permission to be videotaped for evaluation purposes only. The videotape will not be shared outside this office.

_____ _____

Date Signature