Schie SPEECH

Speech Therapy Intake Form

Adult & Adolescent

Patient Name: _____ **DOB:** _____

Who referred you to our office?

_____

_____

Why were you referred to our office?

_____

_____

Does anyone in your family have a history of speech therapy? ☐ Yes ☐ No

If so, who and why?

_____

_____

Work/School History:

☐ **Full-Time Employment** ☐ **Part-Time Employment** ☐ **Student Grade: _____** ☐ **Disability** ☐ **N/A**

If employed, what type of work do you do?

_____

_____

Please describe any issues you are currently experiencing.

_____

_____

_____

_____

How does your problem impact your daily routines?

_____

_____

_____

_____

What are you hoping to accomplish with therapy?

_____

_____

_____

_____