**New Client Intake Form**

**General Information**

Client’s Name:

Guardian’s Name:

Gender:  Male  Female  Other

Date of Birth:

Age:

Email:

Primary Phone Number:

Secondary Phone Number:

Address:

Grade/School:

Referred by:

**Client Background**

Diagnosis:

Likes:

Dislikes:

Other Therapies:

Applied Behavioral Analysis (ABA)

Physical Therapy (PT)

Occupational Therapy (OT)

Other:

Deficits:

Guardian/Client Goals and Requests:

**Availability for Therapy**

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Morning (9 a.m. – 12 p.m.)

Afternoon (1 p.m. – 4 p.m.)

Evening (5 p.m. – 7 p.m.)

**Services**

Session Type:

Individual Therapy

Reading Therapy

Hippotherapy

Social Skills GroupAppointment Type:

*(Please check all that apply)*

Initial Consult

Comprehensive Evaluation with Report

Comprehensive Evaluation without Report

Weekly Therapy

Second Opinion

Previous Speech-language Treatment?

Yes  No

Previous Testing:

Yes  No

If yes, please explain:

Previous Reports/Evaluations

*(Please check all that apply)*

IEP

Speech-language Evaluation

Psycho-educational Evaluation

Neuropsych Evaluation

Audiologist Evaluation

Other:

**After completing this form, please save as "Last Name Intake" (e.g., Reynolds Intake)   
and email it to** [**jmreynolds1231@gmail.com**](mailto:jmreynolds1231@gmail.com?subject=New%20Client%20Intake%20Form)**.**

**For Office Use Only**

Communication Log: