Theresa M. Snelling, M.A., CCC-SLP
Speech-Language Pathologist

- Infant/Toddler * Preschool * School Age * Parent Education * Cleft Palate

CLIENT INFORMATION FORM

Date_____

CHILD'S NAME _____ Date of Birth_____
Child lives with: Both Parents_____ Mother ____ Father____ Guardian _____
Address_____
_____

Parent(s) Name(s):_____
___ Married ___ Divorced ___Separated __Single
Siblings Names and Ages: _____
_____

Home Phone_____
Cell (M) _____ (F) _____
Work Phone (M) _____ (F) _____
EMAIL_____
Can we contact you by email? YES NO

INSURANCE INFORMATION

Insurance Company: _____
ID# of child: _____ Group # _____
ID# of Insured (parent): _____
NAME OF INSURED (parent): _____
Date of Birth of Insured (parent): _____ Sex: M/F
EMPLOYERS Name: _____

Primary Care Physician of child: _____ Phone: _____

HIPPA form signed: Y / N Date: _____

Financial Plan: (check all that apply):
Insurance: _____
Copay: _____ per session
Medicaid: Primary _____
Secondary _____
Private Pay: _____
Per Session: _____
Monthly: _____

Parent/Guardian Signature:
_____ Date: _____

9255 W Alameda Ave. Unit C, Lakewood , CO 80226 * 303-232-5711 * t.snell@hotmail.com

CHILD'S NAME: _____

BIRTH/MEDICAL HISTORY

Birth Weight: _____ Length of pregnancy: _____
Complications at birth: _____
_____
(Please use back of form if more room is needed.)

Pregnancy Complications: _____
_____
Did your child have feeding problems? _____
_____
History of ear infections? _____ # of ear infections: _____ PE tubes: _____
Medical diagnosis: _____
_____
CHILD's Medical Specialists (other than primary care physician:
Name: Location: Phone:
_____
_____
_____
(Please use back of form if more room is needed.)

Surgical History:

Procedure/Surgery	**Age**	**Physician**

(Please use back of form if more room is needed.)

DEVELOPMENTAL HISTORY

At what age did your child:
Crawl? _____ Walk? _____
Say first word? _____ Put 2 words together? _____
Make complete sentences? _____
Did your child babble during the first 6 months of age? _____

Percent of speech you understand? _____% others understand? _____%
Family History of speech/language/learning problems? _____
Explain:_____
_____
_____

Eating/Chewing concerns: _____
_____

CHILD'S NAME: _____

Please describe in your own words your child's speech or language difficulties:

_____
_____
_____
_____
_____

SCHOOL and INTERVENTION INFORMATION

Name of Child's School or Daycare: _____
Does your child have an educational plan (IEP / IFSP)? Yes NO
If yes, with what agency or school district? _____

OTHER THERAPISTS/PROVIDERS (names and phone #'s):
Speech Therapist: _____
Occupational Therapist: _____
Physical Therapist: _____
Other: _____

Previous DEVELOPMENTAL OR SPEECH ASSESSMENTS:
Where? _____
Results? _____
_____
Report Available: Y / N
Diagnosis, if given: _____
_____

I grant permission to **THERESA M. SNELLING, MA,CCC-SLP** to contact/correspond with:
____ Therapists _____ teachers _____physicians _____other (list :_____)
regarding speech therapy and developmental information for my child by:
(Circle all that apply):

Written (IEP/IFSP) Verbal Phone Email

Parent signature and date:

_____ Date: _____

Has your child's hearing been tested? Yes No
Where: _____ When: _____
Results: _____

Who referred you to our office? _____