Speech-Language-Hearing Clinic
Caudell Hall 149
1300 Elmwood Avenue Buffalo,
NY 14222-1095
Tel: (716) 878-3530
Fax: (716) 878-3526

http://speech.buffalostate.edu

Client Registration/Intake Form

Client Name_____ Date _____

Session: Fall _____ Spring _____ Summer-Traditional _____ Summer-Specialty _____

Client Contact Information:

Address _____

City, State, Zip _____

Phone Number _____

Alternate Phone _____

E-mail Address _____

Permission to contact you via e-mail?

Demographics:

Date of Birth _____

Gender _____ Age _____ Grade_____

School *(if applicable)* _____

Language(s) Spoken at Home _____

_____

Presenting Concern:

Please provide a brief description of the area of concern _____

_____

_____

Have you received an evaluation within the past 6 months? *(if yes, submit a copy with registration)*

How did you hear about the clinic? _____

_____

_____

Have you used our services before

If yes, when? _____

Are you currently receiving treatment anywhere else? *(if yes, complete section below)*

Service Location _____

Frequency _____

Service Provider _____

Do we have permission to contact your service provider? *(if yes, provide contact detail below)*

Provider Phone _____

Provider E-mail _____

(CONTINUED ON REVERSE)

Parent/Guardian or Caretaker Information:

Name _____

Relationship _____

Phone Number *(if different)* _____

E-mail Address *(if different)* _____

Address *(if different)* _____

City, State, Zip _____

Race/Ethnicity:

Required by accrediting body. Providing this information is voluntary, confidential and will be reported in aggregate only.

____ White, Non-Hispanic

____ Hispanic/Latino

____ Black or African American

____ Asian

____ American Indian or Alaskan Native

____ Native Hawaiian or other Pacific Islander

____ Other

Please list any allergies:

_____

_____

Billing Information:

Are you a Buffalo State Student or Staff Member?

Are you requesting a scholarship?

Person Responsible for Payment

_____

Phone Number *(if different)*

_____

E-mail Address *(if different)*

_____

Billing Address *(if different)*

_____

City, State, Zip _____

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This section for clinic use only

Date Intake Received _____

Date Evaluation Received _____

Evaluation Forwarded for Review _____

Evaluation Recommended Y or N

Evaluation Scheduled _____

Evaluation Supervisor _____

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Adult Information Form

Client Name _____ Date of Birth _____

Referred By _____

Reason for Referral:

Please check all the difficulties you are experiencing:

☐ Voice ☐ Speaking ☐ Swallowing ☐ Stuttering ☐ Hearing

☐ Understanding language ☐ Other (please explain) _____

Please describe your communication difficulties:

_____

_____

History:

When did you first notice a problem? *(If due to an accident or illness, please describe and state when it occurred.)*

_____

_____

Were you hospitalized? If yes, for how long? _____

Describe any paralysis or weakness _____

_____

Do you have a history of seizures? _____

Describe any visual problems _____

_____

Have you ever worn a hearing aid? Describe any hearing problems _____

_____

How is your current health? _____

_____

Are you taking any medication? If yes, please explain _____

_____

Daily Communication:

How do you currently communicate? _____

_____

_____

Describe any changes in your communication skills since the onset of any difficulties _____

_____

_____

Have you had a previous speech/language evaluation or therapy?

If yes, where & when? *(Please attach copies of any prior evaluations or therapy reports)* _____

_____

Is there anything else you think we should know about you? _____

_____

_____

Educational History:

Please indicate the highest degree or level of school you have completed _____

Describe any special training _____

Employment & Income:

Current Employer _____ Occupation _____

Income Level: *(Required by accrediting body. Providing this information is voluntary, confidential and will be reported in aggregate only.)*

____ Less than $45,000

____ $45,000 to $49,999

____ $50,000 to $59,999

____ $60,000 or more