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)* Yes

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 _____

.....

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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Child Information Form

Client Name _____ Date of Birth _____

Parent/Guardian _____ Referred By _____

School _____ Grade: ____

Reason for Referral:

Please describe your child's communication difficulty _____

_____

_____

When does your child communicate best? _____

_____

With Whom? _____

Doing What? _____

When does your child have the most trouble communicating? _____

_____

Why do you think this is so? _____

_____

Development & Learning History:

How old was your child when he/she started to:

Crawl ____ Walk ____ Say words ____ Combine words (e.g., Mommy go) ____ Use sentences ____

How does your child get what he/she wants? _____

_____

Does he/she understand and follow directions?

Do you think that your child learns more slowly than, about the same as, or more quickly than other children? _____

Has your child ever had a speech/language evaluation? (If yes, when & where?) _____

_____

Has your child ever received speech/language therapy? (If yes, when & where?) _____

_____

Is your child receiving special help (reading, special classes, special instruction in learning English)? _____

_____

Family Information:

Are there any family members who have communication or learning difficulties? _____

_____

Please list any other children living in your household:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is English your child's first language? (If not, what languages are spoken in the home?) _____

_____

Has your child lived anywhere other than Buffalo, NY or its surrounding communities? (If yes, please list)

_____

Medical History:

Is your child in good health? _____

_____

Does your child take any medication(s)? (If yes, please list) _____

_____

Has your child ever had any serious illnesses or injuries? (If yes, please describe) _____

_____

Does your child have any other health problems that you or your doctor are concerned about? (allergies, trouble eating, trouble sleeping) _____

_____

Were there any problems with your pregnancy or birth with this child? _____

_____

Describe any difficulties with eating, chewing, swallowing, drooling _____

_____

Does your child seem to hear well?

Has he/she had any ear infections? If yes, how frequently? _____

Has your child's hearing been tested? If yes, where and what were the results? _____

_____

_____

Household Income: *(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

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Therapy Planning Form

Client's Name _____ Date _____

Date of Birth _____ Person Completing Form _____

Relationship to Client _____

Is the client taking any medications that we should know about?

_____

_____

Food is sometimes used during sessions. Does the client have any food allergies we should know about?

_____

_____

Are there any foods that should not be used in therapy?

_____

_____

Are there any holidays/celebrations that should not be included in therapy activities?

_____

_____

Is there anything else we should know about the client?

_____

_____

_____