SCHIEFELBUSCH SPEECH-LANGUAGE-HEARING CLINIC
2101 Haworth Hall
University of Kansas

Intake Form for Assessment and/or Intervention

Date form completed _____ Date Received _____

Service(s) Requesting (check one) ____ Assessment _____Intervention _____Assessment & Intervention

Preferred Services for Intervention: _____Group _____Individual _____Both

Name of Client _____ Phone (_____)_____

Address _____
Street City State Zip Code

Birthdate _____ Age_____ Email _____

Primary Contact: _____ Relationship to Client:_____
Name

Phone Number: _____ E-mail_____

Physician_____
Name Address Phone

Client referred by_____
Name Relationship to family

Person filling out this questionnaire_____
Name Relationship to Client

Insurance Information:

Primary Insurance:
Insurance Company _____ ID Number_____

Group Name_____ Group ID_____

Policy Holder's Name_____ Policy Holder's DOB_____

Secondary Insurance:
Insurance Company _____ ID Number_____

Group Name_____ Group ID_____

Policy Holder's Name_____ Policy Holder's DOB_____

Office Use Only:
Date Added to Waiting List and by Whom_____