TENNESSEE STATE UNIVERSITY

Speech, Language, and Hearing Clinic

PATIENT INTAKE FORM

DATE _____ **File # __NEW__**

PATIENT'S FULL NAME: _____Circle: Adult / Child

FATHER'S NAME: _____ MOTHER'S NAME: _____

ADDRESS: _____

_____

TELEPHONE: (Home) (____)_____ (Work) (____)_____

EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ MALE: _____ FEMALE: _____

PRIOR SPEECH SERVICES RECEIVED (When) _____ (Where) _____

PROBLEM DESCRIPTION: _____

_____

_____

_____

REFERRED BY: _____ DATE: _____

Our therapy sessions are held twice weekly on the hour on Monday/Wednesday and Tuesday/Thursday. (Note: Please do not schedule between the hours of 12:00 – 1:00 PM.) Please indicate below the days and time, 9:00 am – 4:00 pm, you prefer for therapy.

M/W _____ to _____ Alternate time M/W _____ to _____

T/TH _____ to _____ Alternate time T/TH _____ to _____