

CENTER FOR COMMUNICATION DISORDERS INTAKE SCREENING – PAGE 1 OF 2

NAME: _____ GENDER (M F) D.O.B. ____/____/____ CA.: _____
HOME ADDRESS: _____ CITY: _____ ZIP: _____
PHONE(S) (INCLUDE AREA CODE): H: _____ W: _____
FAX: _____ CELL PHONE: _____
PARENT/GUARDIAN/CONTACT: _____
RELATIONSHIP TO CLIENT: _____
NAME OF INFORMANT FOR THIS QUESTIONNAIRE: _____
RELATIONSHIP TO CLIENT: _____
ADDRESS (IF DIFFERENT FROM CLIENT): _____
PHONE (IF DIFFERENT): _____
PRIMARY LANGUAGE OF CLIENT: _____ IF CHILD, IS S/HE IN FOSTER CARE? _____
IF YES, PERSON AUTHORIZED TO SIGN FOR CHILD: _____
DATE OF INITIAL INQUIRY CALL: _____ TAKEN BY: _____
APPOINTMENT SCHED. FOR: _____
(day) (date mm/dd/yy) (time) (supervisor)

QUESTIONS TO ASK THE INFORMANT

1. PLEASE INDICATE THE SERVICES THAT CLIENT IS SEEKING.

- SPEECH-LANGUAGE THERAPY (YES/NO) _____ IF YES, THEN SEND PACKET REQUESTING RECENT DIAGNOSTIC INFORMATION.
- SPEECH-LANGUAGE DX (YES/NO) _____ TYPE: (please circle one of the following:) VOICE FLUENCY ARTIC LANGUAGE AAC NEURO.(e.g., APHASIA GROUP) OTHER
- AUDIOLOGICAL SERVICES (please check one of the following, if applicable)
EVALUATION AND PRESCRIPTION _____ REPAIR _____
EARMOLD _____ ADULT REHAB _____
HEARING AID ORIENTATION _____ CAPD _____

2. PLEASE DESCRIBE THE COMMUNICATION PROBLEM THAT THE CLIENT IS EXPERIENCING.

3. WHAT CAN WE DO TO HELP YOU MOST?

4. WERE YOU REFERRED TO US BY SOMEONE? (YES/NO)

IF YES, WHO?

IF NO, HOW DID YOU HEAR ABOUT US?

5. HAS THE CLIENT RECEIVED ANY HEARING OR SPEECH-LANGUAGE EVALUATIONS OR SERVICES ELSEWHERE? (YES/NO)

IF YES, WHERE?

MAY WE CONTACT THEM? (IF YES, EXPLAIN RELEASE FORM)

6. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW BEFORE WE SEE

_____?
(client's name or appropriate pronoun)

PAYMENT (please indicate one of the following):

Client/parent/guardian _____

Fee waived: client is an SCSU student _____ **SCSU faculty/staff member** _____

SCSU faculty/staff family member _____

School District _____

Client has requested consideration for fee reduction/waiver _____