



Therapies of the Rockies
Speech and Language Therapists

Patient Intake Form

Name: _____ Date of Birth: _____ M ___ F ___
Social Security # _____ Telephone: _____
Home Address: _____
City: _____ State GA Zip Code _____
School/Daycare _____ Grade/Teacher _____
Referral Source: _____
Responsible Party _____
Relationship to Child _____ Telephone: _____

Name of Spouse/Guardian: _____ Telephone: _____
Home Address: _____
City _____ State _____ Zip Code _____
Employer _____ Telephone _____
Email address: _____

Name of Father/Guardian _____ Telephone _____
Home Address: _____
City _____ State _____ Zip Code _____
Employer _____ Telephone _____
Email address: _____

Primary Insurance:

Name of Insured: _____ Date of Birth: _____
Social Security Number _____ Relationship to Patient _____
Insurance Company Name _____
Claims Address _____
City/State/Zip Code _____
Customer Service Telephone _____ Group Name _____
Policy Number _____ Group Number _____

Additional Insurance:

Name of Insured: _____ Date of Birth: _____
Social Security Number _____ Relationship to Patient _____
Insurance Company Name _____
Claims Address _____
City/State/Zip Code _____
Customer Service Telephone _____ Group Name _____
Policy Number _____ Group Number _____

Patient Health History:

Pediatrician/Primary Doctor: _____ Tel: _____ Fax: _____
Address/City/State/Zip Code _____
Date of Last visit _____ Purpose _____
Is your child currently being treated for any medical condition? Yes ___ No ___
Who is treating your child for this condition? _____
Telephone number of treating physician _____
Description of condition/treatment: _____
Is your child currently taking any medications? Yes ___ No ___
Prescription Name _____ For _____
Prescription Name _____ For _____
Prescription Name _____ For _____
Additional medical information related to your child: _____

What is your primary concern regarding your child's/ or your communication skills?

