**Client Intake Form**

**Client Information**

**Client Name:**

**Date of Birth:**

**Primary Phone:**

**Client’s Primary Email:**

**Current Address:**

**Spouse/Primary Caregiver:**

**Spouse/Primary Caregiver Phone/Email:**

**Emergency Contact Information**

**Emergency Contact:**

**Emergency Contact’s Phone:**

**Email:**

**Appointed Power of Attorney & Financial Advisor**

**Power of Attorney (POA)/Appointed Guardian:**

**POA/Guardianship Activated (place X next to one): Yes No**

**POA Phone:**

**POA Email Address:**

**Financial Advisor/Financial POA:**

**Financial Advisor’s Phone & Email:**

**Client Intake Form**

**Referral Source & Primary Care Information**

**Referring Medical Doctor:**

**Practice Address:**

**Office Phone & Fax Number:**

**Other Referral Source (Self, Website, Facebook, Google, Advocate, LSW, other):**

**Patient’s Medical History:**

**Patient’s Medications(s):**

**Current Area(s) of Concern/Impairment/Requests for Assessment:**

**Patient’s Insurance(s) (Please check all that apply & write name of insurance carrier(s):**

* ***Medicare plan: Traditional (80%)* ¥**
* ***Medicare advantage plan:* ¥ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* ***Private insurance plan: (20%)* ¥ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* ***Additional Supplemental Plans: (ONLY for a Tertiary plan)* ¥ \_\_\_\_\_\_\_\_\_\_\_**

***(\*office use only\*)***

**Appropriate for Treatment: Yes No**

**Client/POA Consent to Evaluation:**

**Clinician Initials/Signature: C.M.B./Christina Buchanan, M.S., CCC-SLP**

**Date of Intake:**