



- Downtown
- Northwest
- Southwest
- North
- Shafter

- Patient Information
- Insurance Information
- Insured's DOB
- Injury / Condition
- Medical History

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____ Zip: _____
 Work Phone: _____ Home Phone: _____ Cell Phone: _____
 SS#: _____ DOB: _____ Sex: M F Martial Status: Single Married Other
 Age: _____ Height: _____ Weight: _____ E-mail: _____
 Occupation: _____ Currently Working: Y N Employer: _____
 Work Restrictions per MD: Y N Attorney: Y N Attorney Name: _____
 Person to contact in case of emergency:
 Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION (PLEASE COMPLETE ALL INSURANCE INFORMATION)

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ Subscriber Number: _____
 Group Number: _____ Subscriber Name: _____ Relationship: _____
 Subscriber DOB: _____ Subscriber SSN: _____ - _____ - _____ Insured Employer: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ Subscriber Number: _____
 Group Number: _____ Subscriber Name: _____ Relationship: _____
 Subscriber DOB: _____ Subscriber SSN: _____ - _____ - _____ Insured Employer: _____

Communication Concerns

Describe your concerns about your speech and language problems _____

 When were these concerns first noticed? _____
 Has the problem changed since it was first noticed? _____
 What do you think may have caused the problem? _____
 What are your strengths? _____
 Have you seen any other speech language specialists? _____
 Do you currently receive any other therapies or services? If so, please describe _____

 Please provide any other information that might be helpful in evaluation or treatment _____

