Cobblestone
Speech, Language & Learning

Date: _____/_____/_____

Child Intake

CHILD INFORMATION

Please Type or Print in Ink

Child's Name: _____ _____ _____
Last Name First Name MI

DOB: _____ Age: _____ Gender: ☐ F – Female ☐ M – Male

Address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

FAMILY INFORMATION

Please Check Appropriate Boxes and Type or Print in Ink

Mother's Name:	**Mother's Employer & Title:**

Mother's Primary Phone: (please check one) ☐ H ☐ C ☐ W _____

Mother's Secondary Phone: (please check one) ☐ H ☐ C ☐ W _____

Mother's E-mail Address: _____

Father's Name:	**Father's Employer & Title:**

Father's Primary Phone: (please check one) ☐ H ☐ C ☐ W _____

Father's Secondary Phone: (please check one) ☐ H ☐ C ☐ W _____

Father's E-mail Address: _____

Name of Siblings	Age	Gender	Name of Siblings	Age	Gender
		☐ F ☐ M			☐ F ☐ M
		☐ F ☐ M			☐ F ☐ M
		☐ F ☐ M			☐ F ☐ M

With whom does your child live? ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

RELATED HISTORY

Please Check Appropriate Boxes

Does your child have an Individualized Education Plan (IEP)? ☐ Y ☐ N

Has your child had a previous speech/language evaluation? ☐ Y ☐ N

Please describe your child's medical history:

_____

_____

_____

CONSENT TO TREAT MINOR

Please Type or Print in Ink & Sign

This Consent Form provides Cobblestone Speech Therapy with the authority to provide evaluations, treatment, and consultative services, as well as the authority to exchange and share information with previously specified therapists, physicians, and/or service providers for my child. We/I acknowledge that no guarantees have been made to me as to the results of treatment for my child. We/I hereby give consent to Cobblestone Speech Therapy to treat my child.

Mother's Name (Print): _____ **Mother's Signature:** _____

Father's Name (Print): _____ **Father's Signature:** _____

Cobblestone Speech, Language and Learning LLC, 10579 Bradford Road, Suite 104, Littleton, CO 80127
Phone: (303) 952-9038 | Fax: (720) 389-7067 | E-mail Address: cobblestonespeech@gmail.com | www.cobblestonespeech.com

Cobblestone
Speech, Language & Learning

Child Intake (Cont'd)

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION Please Check Appropriate Boxes and Type or Print in Ink

I, _____, give Cobblestone Speech, Language and Learning permission to:

OBTAIN/RELEASE WRITTEN AND/OR VERBAL INFORMATION REGARDING MY CHILD:

Child's Name: _____ **DOB:** _____

From/to the following persons or agencies:

	Name	Phone	Address
☐ **Pediatrician**			
☐ **Teacher**			
☐ **Dentist**			
☐ **Other Professional (Please specify)**			

Parent Signature: _____ **Date:** _____

PERMISSION FOR AUDIO VISUAL RECORDING Please Check Appropriate Box & Sign

On occasion, therapy sessions are videotaped. These recordings are used to improve treatment outcomes and document progress. On occasion, these videos are used for training purposes. Identifying information is limited to the child's first name and age at the time of the recording. All video and audio recordings are securely stored on our clinic's computer system. Copies of the recordings are available to you, the parents, on request.

Audio and visual recordings are often a necessary part of assessment and intervention.

Please check the appropriate box below and sign, indicating your authorization for use of audio and/or visual recordings for training purposes.

☐ **I AUTHORIZE THE USE OF VIDEO TAPES FOR THE PURPOSES OF TRAINING.**

Parent Signature: _____ **Date:** _____

☐ **I <u>DO NOT</u> AUTHORIZE THE USE OF VIDEO TAPES FOR THE PURPOSES OF TRAINING.**

Parent Signature: _____ **Date:** _____

REFERRED BY Please Check One and Type or Print in Ink

	Name	Phone	Address
☐ **Pediatrician**			
☐ **Dentist**			
☐ **School**			
☐ **Other Professional (Please specify)**			
☐ **Friend**			