INTAKE FORM

Date questionnaire completed:

CHILD'S NAME:
Male or Female:
Date of Birth:
Age:

PARENT/GUARDIAN (Please underline one: Father / Mother / Guardian)
NAME: **DOB:**
Employer:
Occupation:
Work Phone:
Cell Phone:
Email:
Home Address (If different from other parent or guardian):
City:
State:
Zip Code:
Home Phone:

PARENT/GUARDIAN (Please underline one: Father / Mother / Guardian)
NAME: **DOB:**
Employer:
Occupation:
Work Phone:
Cell Phone:
Email:
Home Address (If different from other parent or guardian):
City:
State:
Zip Code:
Home Phone:

Kidspeak, ltd.
specialized speech & language and occupational therapy services

6936 garland lane north
maple grove, mn 55311
fax (763) 416-4530 **tel. (763) 416-9313**

CHILD RESIDES AT THE FOLLOWING ADDRESS (If different from above):

Home Address:

City:

State:

Zip Code:

HOW DID YOU LEARN ABOUT KIDSPEAK?

Response:

PRIMARY OR REFERRING DOCTOR:

Doctor's Address:

Phone:

DATE OF PRESCRIPTION OR REFERRAL FROM PHYSICIAN (Required to provide diagnosis for submitting claims to insurance):

DIAGNOSIS: **DATE OF ONSET**:

INSURANCE COMPANY:
Claims Address:
Insurance Company Phone Number:

Insurance Company Fax Number:

Subscriber's Name:

Subscriber's Date of Birth:

Subscriber's Relationship to Child (i.e. Father or Mother):

Id Number (Please Include Alpha Characters):

Name of Insured Group or Employer:

Group or Plan Number:

Kidspeak, ltd.
specialized speech & language and occupational therapy services

6936 garland lane north
maple grove, mn 55311
fax (763) 416-4530 **tel. (763) 416-9313**

PLEASE DESCRIBE THE MAJOR CONCERNS YOU HAVE AS TO WHY YOU ARE SEEKING SPEECH AND/OR OCCUPATIONAL THERAPY FOR YOUR CHILD:

Does your child have a diagnosis?
What are you most concerned about now?

Kidspeak, ltd.
specialized speech & language and occupational therapy services

6936 garland lane north
maple grove, mn 55311
fax (763) 416-4530 **tel. (763) 416-9313**