**Client Intake Form**

Name       Today’s Date

Legal Name if Different       Name on Insurance Card

Medicare Number       Medicare-Secondary Insurance Number

Sex Assigned at Birth       Gender Identity       Pronoun

Date of Birth       Age       Height       Weight

Full Address

Phone

Email

Occupation

Name, Email, and Phone of Emergency Contact Person

Who Referred You

Onset of Stuttering

1. How severe do you feel your stuttering is currently?

2. What seems to improve your speech?

3. What seems to make your speech worse?

4. Have you had speech therapy in the past? When and for how long?

5. Do you have any chronic conditions, such as seasonal allergies, asthma, diabetes, or other?

6. What medications are you taking (for anything)?

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