**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

Who Referred You

Name, Email, and Phone of Emergency Contact Person

1. What concerns do you have about your voice, throat, speech, communication, singing, or swallowing?

2. What goal(s) do you have regarding your voice, throat, speech, communication, singing, or swallowing?

3. Have you been diagnosed with an illness of the vocal cords, larynx, or upper airway related to your voice, throat, speech, communication, singing, or swallowing?

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

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

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