



1. Name of client \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

2. Why you are requesting services from this company?

\_\_\_\_\_.

3. At the end of this experience what would you have hoped to have gained?

\_\_\_\_\_  
\_\_\_\_\_.

4. Where do you see yourself (your child) in five years? \_\_\_\_\_ Ten years? \_\_\_\_\_.

5. Have you or your child received speech therapy in the past? Yes No  
From whom? \_\_\_\_\_ How long? \_\_\_\_\_.

6. How many minutes per day do you assist yourself or your child with improving articulation/communication? \_\_\_\_\_.

7. Do the child's parents have a history of speech delays? If so, please explain.

\_\_\_\_\_  
\_\_\_\_\_.

8. What are some things that you (your child) enjoy?

\_\_\_\_\_

9. Do you (your child) have allergies?

\_\_\_\_\_.

10. Are you (or your child) presently on any medication?

\_\_\_\_\_

11. Is there anything you would like me to know about you (or your child)?

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**Services, Payments, Insurance**

**SLP Communications Solutions is a private corporation, which prides itself on providing compassionate service in a friendly environment. Because this is a small corporation, we are not in a position to bill private insurance companies; however we are committed to providing detailed billing and therapy logs, so that if you choose to seek reimbursement from your insurance carrier, you may do so. All payments are expected at the end of each session, unless another arrangement is made, in writing, between SLP Communications Solutions, Inc. and the client. Please sign below indicating that you understand this policy.**

\_\_\_\_\_  
Signature of Parent/Guardian/Client

\_\_\_\_\_  
Printed Name of Parent/Guardian/Client