Laura LeBlanc MA, CCC/SLP

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(561) 827-2673

I. Identification:

Name:_____DOB:_____ Age_____
Address:_____
Languages spoken:_____ Phone:_____Email:_____
Preferred method of communication: text _____ phone call_____

II. Medical History:

List any medications you are taking:
_____
List any known allergies_____
List any surgeries_____
Do you have any hearing/vision concerns? Yes_____ No_____

III. Previous Speech Treatment:

Have you ever received speech/language treatment?

Yes_____No _____

If yes where?_____

Describe the results of the previous treatment and reason for discontinuing (if applicable)

_____

_____

VI. Circle Areas of Concern:

speech intelligibility word finding memory receptive/expressive language social language skills
stuttering auditory processing voice reading comprehension written language

Preferred days/times for therapy:

_____

Form completed by (print name) _____Date:_____
Signed;_____

Please email completed form to lauraleblancslp@gmail.com