Crystal Y. Sanford, M.Ed., M.A., CCC-SLP
Speech-Language Pathologist/Owner
Sanford Autism Consulting
Phone: (619) 403-9097
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OFFICE USE ONLY	
ID	
DATE	
OTHER	

INTAKE SHORT FORM-SOCIAL GROUPS

CHILD'S INFORMATION			
FULL NAME		GENDER ☐ Male ☐ Female	DOB
CURRENT AGE	NAME OF SCHOOL		GRADE
PARENT NAME		PARENT PHONE	
PARENT EMAIL		DATE:	

DIAGNOSES/MEDICAL CONCERNS/MEDICATION	
PARENT CONCERNS Communication Academics Peer Relations Behavior/Sensory Regulation Placement/School Day Experiences	
CHILD CONCERNS	
TEACHER CONCERNS	
CONCERNS OF OTHERS	Please specify. (Physician, family members, etc.)

OTHER SERVICES AND EVALUATIONS

☐ None

TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

REFERRAL SOURCE	
To be completed by clinician: PLAN FOR FOLLOW UP	

CLIENT NAME

PARENT NAME

PARENT SIGNATURE

DATE