Application For Services

Client's Information

First Name	Last Name	Date of Birth (MM/DD/YYYY)

Gender	Relationship to Concordia

List any medical or educational diagnoses client may have (e.g. aphasia, autism, cognitive disability etc.)

Parent/s or Guardian/s Information *(if applicable)*

First Name	Last Name	Relationship to Client	Relationship to Concordia

Contact Information

Please provide your mailing address

Street		
City	**State**	**Zip**

Please check the box next to the best way to contact you

Home Phone	
Work Phone	
Cell Phone	
Email Address	

Referral

The person who recommended you to this clinic.

First Name	Last Name	Relationship to Client / Family

Areas of Concern

Select All That Apply:

Feeding/Swallowing	Social Skills
Hearing	Speech
Language	Stuttering
Learning/Cognition	Writing
Reading	Other

What is the concern and reason for seeking our services (evaluation, treatment, both?)

Person Completing Form

First Name	Last Name	Relationship to Client	Today's Date (MM/DD/YY)

After completion, save the file, and email the saved file as an attachment to SLH.Clinic@cuw.edu, with "APPLICATION FOR SERVICES" in the subject line.

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