



Client name: _____ **D.O.B:** _____

Date of Session: _____

Start time: _____ **Finish time** _____

Aims of Session:

Therapy Session:

Subjective:

Objective:

Assessment:

Plan:

Advice given (client/parents/carers/teaching staff)

Signature of Therapist: _____ **Date:** _____

**Speech and Language Therapist
Integrated Treatment Services**