Gifts
SPEECH, LANGUAGE & READING SPECIALISTS

History Form

Name: _____ Social Security #: _____
Birth date: _____ Age: _____

Mother's Name: _____ Social Security #: _____
Cell phone #: _____ Work phone #: _____
Father's Name: _____ Social Security #: _____
Cell phone #: _____ Work phone#: _____

Physical Address: _____
Street Apt. # City Zip Code

Mailing Address: _____
Street Apt. # City Zip Code

Home Telephone: _____ E-mail: _____
Preferred Contact Method: _____

Child Lives With: _____ Siblings: _____
Referred By: _____
Pediatrician: _____ Phone: _____

Primary Language Spoken in the Home: _____
Secondary Language Spoken in the Home: _____

School: _____ Principle: _____
Grade: _____ Teacher: _____

Description of Problem (please be specific): _____
_____
_____
_____

Has your child been tested previously or received services for speech, language, reading and/or hearing?
_____ yes _____ no
If yes, where? _____ When? _____
How long? _____

Does your child have a current IEP (Individual Education Plan)? _____
Is your child currently receiving services? _____

Birth / Medical History: _____
_____
Allergies / Medications: _____
Insurance Coverage: _____