



History Form

Name: _____ Social Security #: _____
Birthdate: _____ 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 Phone #: _____ E-mail: _____
Preferred Contact Method: _____

Child Lives With: _____ Siblings: _____

School: _____ Principal: _____
Grade: _____ Teacher: _____

Referred By: _____

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)? _____ yes _____ no
Is your child currently receiving services? _____ yes _____ no

Birth/Medical History: _____

Allergies/Medications: _____

Insurance Coverage: _____