Silver State
SPEECH THERAPY

Child/Client's Name: _____
Date of Birth: _____
Parent/s Name(s): _____
Referring Physician: _____
Primary Care Physician: _____
Address:_____
Phone Number:_____
Primary Insurance (Please include member ID):_____
_____
_____
Secondary Insurance (Please include member ID):_____
_____
_____
_____
Current Medications:_____
_____
History of main complaint/
concerns_____
_____
_____ _____
_____
Medical History-Are there any pertinent medical issues or have there been major surgeries?
_____ _____
_____
_____
Social History-Who does the child live with and who else is present in the home?
_____
_____
Does your child have any allergies or dietary restrictions? _____
_____
Is your child in school? If so, what grade are they in and what school do they attend?
_____
Do they receive therapy in school?_____
What are your goals for your child?_____
_____
_____
Desired therapy location (Home, School, Daycare)_____