HISTORY AND INFORMATION FORM
PRINT OR FAX TO: 603-893-8680

Identification Information

Current Date: ______________________

Name ______________________ Date of Birth ______________________

Address ______________________ Phone Number ______________________

City __________ State ____ Zip Code __________ Cell Number ______________________

Country ______________________ Email ______________________

Occupation ______________________ Work Number ______________________

Marital Status ______________________ Spouse's Name ______________________

Children (include names, gender, ages): ______________________

Who lives in the home: ______________________

Diagnosis (if any): ______________________

Referring physician: ______________________ Phone : __________ Fax: __________

Address: ______________________ City: __________ State: ______ Zip: ______

Insurance Information

Primary Insurance Company: ______________________ Phone : __________ Fax: __________

Address: ______________________ City: __________ State: ______ Zip: ______

Name of Insured: ______________________

Identification #: __________ Policy #: __________ Group #: __________

Is this person covered under another insurance policy?: ______ (If no, skip secondary insurance)

Secondary Insurance Company: ______________________ Phone : __________ Fax: __________

Address: ______________________ City: __________ State: ______ Zip: ______

Name of Insured: ______________________

Identification #: __________ Policy #: __________ Group #: __________

Speech THERAPY SOLUTIONS, INC.

Statement of the Problem

Reason for referral: ______________________

Describe what you perceive as your speech and/or language problem: ______________________

What languages do you speak? If more than one, which one is your primary language?: ______________________

What is the highest grade, diploma, or degree earned?: ______________________

What do you think caused the problem?: ______________________

Has the problem changed since it was first noticed?: ______________________

Have you seen any other Speech-Language Pathologists? Who and When? What were their conclusions or suggestions?: ______________________

Have you seen any other specialists (physicians, neurologists, etc.)? If yes, indicate the type of specialist, when you seen, and the specialist's conclusions or suggestions. ______________________

Are there any other speech, language, learning, or hearing problems in your family? If yes, please describe. ______________________

Medical History

Provide the approximate ages at which you suffered the following illnesses or conditions:

Adenoidectomy:	________	Headaches:	________	Encephalitis:	________
Chicken Pox:	________	Allergies:	________	Hearing Loss:	________
Croup:	________	Colds:	________	Asthma:	________
Ear Infections:	________	Dizziness:	________	Convulsions:	________
Draining Ear:	________	German Measles:	________	High Fever:	________
Influenza:	________	Mastoiditis:	________	Measles:	________
Meningitis:	________	Mumps:	________	Noise Exposure:	________
Otosclerosis:	________	Pneumonia:	________	Seizures:	________
Sinusitis:	________	Tinnitus:	________	Tonsillectomy:	________

Other: ____

Do you have any eating or swallowing difficulties? If yes, please describe: ____

List all medications you are currently taking: ____

Are you having any negative reactions to these medications? If yes, please describe: ____

Describe any major surgeries, operations, or hospitalizations (include dates): ____

Describe any major accidents: ____

Provide any additional information that might be helpful in the evaluation or remediation process: ____

Speech THERAPY SOLUTIONS, INC.

Other Information

How did you hear about Speech Therapy Solutions?

- ◯ Referral
- ◯ insurance company
- ◯ printed phonebook
- ◯ online phonebook
- ◯ webpage

Person completing this form: ____________________

Relationship: ____________________

____________________ Date ____________________
Signed By