Center For Neuro Development

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Client History and Program Application

Please use Black Ink ONLY

Today's Date_______________________________________

Form is completed by Self ______ Spouse_______ Parent _____ Guardian _____ (Check One)

Client's Name __________________________ Date of Birth ____________________________

Address_____________________________ Telephone Home_____________________

City _______________________________ Work _____________________

State_____________Zip Code ___________ Fax _____________________

Country_____________________________ Email Address ______________________

Mailing Address (if different than above) ____

Client lives with: Self____ Spouse _____ Parent _____ Guardian ____ Other _____ (Check One)

Is the client adopted? Yes ______ No ________

Father's Name________________________ Date of Birth ________________________

Address __________________________ Telephone Home________________

City ____________________________ Work ________________

State____________Zip Code_________ Fax___________________

Country __________________________ Email Address___________________

Occupation _______________________ Education Completed ________________

Mother's Name ______________________ Date of Birth ________________________

Address __________________________ Telephone Home________________

City ____________________________ Work ________________

State____________Zip Code_________ Fax___________________

Country __________________________ Email Address___________________

Occupation _______________________ Education Completed ________________

Guardian's Name ____________________ Date of Birth ________________________

Address __________________________ Telephone Home________________

City ____________________________ Work ________________

State____________Zip Code_________ Fax___________________

Country __________________________ Email Address___________________

Occupation _______________________ Education Completed ________________

Client's Name ________________________________ Date ______________________

Siblings:

Name ____ Age ______________

Name ____ Age ______________

Name ____ Age ______________

Name ____ Age ______________

Name ____ Age ______________

Name ____ Age ______________

Name ____ Age ______________

Name ____ Age ______________

MEDICAL HISTORY

Family Physician____________________________________ Telephone ______________

Address ____

Client's birth weight _______ lbs. ____ oz. Apgar Scores (If known) 1. ________ 2. __________

Length of pregnancy ____________ Complications during pregnancy and/or delivery? Yes No

Please describe____

____

____

Age of client when parent first had any concerns about development _________________________

Pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date	Examined by	Diagnosis	Recommendations

Surgeries? Yes No

Please describe____

____

Broken limbs? Yes No

List Specifics

Are there any medical problems which place limitations on physical activity, etc?

List ____

Client's Name ______________________________ Date ______________________

Seizures? Yes No

Frequency______________________________ Length ____________________

Types ____

Currently taking seizure medication? Yes No

List medication(s) ______________________________________

Seizure medication taken previously? Yes No

List medication(s) ______________________________________

Other medications? Yes No

List medication(s) ______________________________________

Describe the client's diet____

____

	Excessive	Daily	Weekly	Rarely	Never
Vegetable	________	________	________	________	________
Fruits	________	________	________	________	________
Meats	________	________	________	________	________
Sugar	________	________	________	________	________
Artificial colorings	________	________	________	________	________
Dairy products	________	________	________	________	________
White flour	________	________	________	________	________
Tobacco	________	________	________	________	________
Alcohol	________	________	________	________	________

List dietary supplements and vitamins

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Food allergies? Yes No Never Tested

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Food cravings? Yes No **Picky eater?** Yes No **Overeats?** Yes No **Poor appetite?** Yes No

Client's Name ____ Date ____________________________

Allergies? Yes No

Please describe ____

Does client have a history of colds or sinus congestion Yes No

Does the client have a history of ear infections Yes No

Which ears have been affected? Left Right Both

Does the client have a hearing loss? Yes No

Does the client have hypersensitive hearing? Yes No

Has the client had a tympanogram? Yes No

What were the results ____

Has the client had an eye examination? Yes No

Does the client wear glasses or contact lenses? Yes No

Prescription ____

Has the client ever received vision therapy? Yes No

Please describe ____

____

Has the client been diagnosed with any of the following: (Please check)

_____ near sighted _____ far sighted _____ astigmatism _____ amblyopia

_____ strabismus _____ macular problems _____ glaucoma _____ cataracts

_____ nsytagmus _____ blind _____ cortical blindness _____ other

Sleeptimes from ____________to __________ Naps from ________________ to ________________

Client physical activity level

Daily Yes No How many days per week ____________________________________

Types of activities ____

Duration of activities ____

Is the client seeing a specialist? Yes No (Please check)

_____ Neurologist _____ Counselor Other _________________

_____ Psychologist/Psychiatrist _____ Chiropractor ______________________

_____ Nutritionist _____ Speech therapist ______________________

_____ Physical therapist _____ Occupational therapist ______________________

_____ Vision therapist _____ Orthopedist ______________________

_____ Cardiologist _____ Tutor ______________________

Other health problems? Yes No

List ____

____

____

Client's Name ____ Date ___________________________

BEHAVIOR

Does the client have a history of emotional or behavioral disorders? Yes No

Please describe ____

Is there a family history of emotional or behavioral disorders? Yes No

Please describe ____

Client's specific positive behaviors ____

Client's specific negative behaviors ____

Do you have specific behavioral goals for the client? Yes No

Please describe ____

distractibility	Yes No Not sure	likes competitive games	Yes No Not sure
short attention span	Yes No Not sure	avoidance behavior	Yes No Not sure
hyperactive	Yes No Not sure	difficulty following directions	Yes No Not sure
hypoactive (low activity)	Yes No Not sure	difficulty with parents	Yes No Not sure
rigid or inflexible	Yes No Not sure	difficulty with siblings	Yes No Not sure
impulsive	Yes No Not sure	difficulty with teachers	Yes No Not sure
temper tantrums	Yes No Not sure	difficulty with peers	Yes No Not sure
sucks thumb	Yes No Not sure	oversensitive to sounds	Yes No Not sure
few or no friends	Yes No Not sure	overly sensitive to touch	Yes No Not sure
socially immature	Yes No Not sure	overly sensitive to odors	Yes No Not sure
perseverating		tics	Yes No Not sure
(talking on a topic)	Yes No Not sure	phobias	Yes No Not sure
low frustration level	Yes No Not sure	emotional	Yes No Not sure
overreacts	Yes No Not sure	overly sensitive	Yes No Not sure
destructive behavior	Yes No Not sure	high tolerance for pain	Yes No Not sure
aggressive behavior	Yes No Not sure	low tolerance for pain	Yes No Not sure
cyclical behavior		compliant	Yes No Not sure
(good days/bad days)	Yes No Not sure	cooperative	Yes No Not sure
academic out put		obedient	Yes No Not sure
(good days/bad days)	Yes No Not sure	organized	Yes No Not sure

PHYSICAL MOTOR SKILLS (Please check problem areas)

low muscle tone	_____________	athotoid movement	_______________
high muscle tone	_____________	ataxic	_______________
coordination	_____________	weak	_______________
crawling	_____________	balance	_______________
walking	_____________	other	_______________
running	_____________		_______________

Client's Name ____ Date ___________________________

HAND PREFERENCE

	Right	Mixed	Left
writing	____________	____________	____________
eating	____________	____________	____________
throwing	____________	____________	____________
brushing teeth	____________	____________	____________
combing hair	____________	____________	____________
sports	____________	____________	____________
other________________	____________	____________	____________
_____________________	____________	____________	____________

LANGUAGE AND READING SKILLS

articulation problems	Yes No Not sure	mirror writing	Yes No Not sure
stammer or stutter	Yes No Not sure	forgetful	Yes No Not sure
Aphasia	Yes No Not sure	right, left confusion	Yes No Not sure
poor pencil grasp	Yes No Not sure	poor judge of time	Yes No Not sure
sloppy writing	Yes No Not sure	poor reading ability	Yes No Not sure
difficulty copying		poorly organized	Yes No Not sure
from blackboard	Yes No Not sure	letter reversals	Yes No Not sure

MATH RELATED

Problems with math:

computation	Yes No Not sure	word problems	Yes No Not sure
concepts	Yes No Not sure	poor logic	Yes No Not sure

DEVELOPMENTAL HISTORY

Age			
	crawled (on stomach)	______ years	______ months
	crept (on hands and knees)	______ years	______ months
	walk	______ years	______ months
	toilet trained	______ years	______ months
	first word	______ years	______ months
	use of couplets (two words together)	______ years	______ months
	3-4 word phrases	______ years	______ months
	sentences	______ years	______ months
	conversational language	______ years	______ months
	read	______ years	______ months

Client’s Name ____ Date ___________________________

Does the client enjoy watching television? Yes No

Does the client enjoy being read to? Yes No

Does the client enjoy reading books? Yes No

Speech and language problems? Yes No

Fine motor problems? Yes No

Gross motor problems? Yes No

Does the client bed wet? Yes No

EDUCATIONAL HISTORY

List all schools attended, years attended, grade completed or degrees earned.

____

____

____

____

____

____

List any educational problems.

____

____

____

List any labels, classifications, or educational diagnoses

____

____

List any exceptional abilities, academic, physical, artistic, musical. . .

____

____

____

____

Lessons (musical, physical/sports, art, language, etc.

____

____

Are there any events which may be currently affecting the client adversely? Yes No

Please describe ____

____

Client's Name ____ Date _____________________________

GOALS AND PLAN

What are your goals and expectations?

____

____

____

____

____

Who will implement the program? ____

____

Daily length of time parents can work with client? ____

Daily length of time others can work with client? ____

____

____

How/When did you hear/learn about our program? ____

What have you done to orient yourself to our program? ____

Which book(s) have you read or which audio/visual or seminar have you heard/viewed? ______________

____

____

We are dedicated to assisting individuals in the achievement of their God-given potential. Further, we are committed to continually investigate, research and utilize the best methods available in this endeavor. Program recommendations are not medical, therapeutic, or psychological prescriptions and are offered for the client and their family to review, investigate and for their education. Use of our Program recommendations is the responsibility of the client and their family. Maggie Dail is an educator, she is not licensed to, nor does she intend to practice medicine or offer medical advice. If medical or other licensed professional advice is needed the family is urged to consult with the appropriate licensed professionals.

I acknowledge that I have read and completed this information to the best of my knowledge and ability, and I understand that neither the Staff of Special Helps nor those trained by or who might be employed or associated with it, are assuming any responsibility or liability for the client and how we might use their program recommendations. I, as the parent, guardian, or client, assume full responsibility and agree to hold any and all parties associated with Special Helps faultless.

Signature ____ Date _____________________________

Signature ____ Date _____________________________