Center For Neuro Development

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Client History and Program Application

(If filled out by hand , please use black ink.)

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____

Please describe ____

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

Please describe ____

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 ____

(For the following please answer: Yes, No or Not Sure.)

distractibility______________________________

short attention span__________________________

hyperactive_________________________________

hypoactive (low activity)______________________

rigid or inflexible____________________________

impulsive___________________________________

temper tantrums______________________________

sucks thumb_________________________________

few or no friends_____________________________

socially immature_____________________________

perseverating (talking on a topic)_______________

low fustration levels__________________________

overreacts__________________________________

destructive behavior__________________________

aggressive behavior___________________________

cyclical behavior(good/bad days)________________

cooperative_________________________________

obedient____________________________________

academic output (good/bad days)________________

likes competitive games ______________________

avoidance behavior__________________________

difficulty following directions _________________

difficulty with parents_______________________

difficulty with siblings ______________________

difficulty teachers __________________________

difficulty with peers ________________________

oversensitive to sounds_______________________

oversensitive to touch________________________

oversensitive to odors________________________

tics _______________________________________

phobias ____________________________________

emotional __________________________________

overly sensitive______________________________

high tolerance for pain _______________________

low tolerance for pain________________________

compliant ___________________________________

organized ___________________________________

PHYSICAL MOTOR SKILLS (Please check problem areas)

low muscle tone _____________

high muscle tone _____________

coordination _____________

crawling _____________

walking _____________

running _____________

athotoid movement _______________

ataxic _______________

weak _______________

balance _______________

other _______________

____

Client's Name ____ Date ___________________________

HAND PREFERENCE

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

LANGUAGE AND READING SKILLS (Please answer: Yes, No or Not Sure)

articulation problems___________________________

stammer or stutter____________________________

aphasia_______________________________________

poor pencil grasp_____________________________

sloppy writing________________________________

difficulty copying (from blackboard)______________

stammer or stutter____________________________

poorly organised______________________________

mirror writing _________________________________

forgetful ______________________________________

right, left confusion ___________________________

poor judge of time _____________________________

poor reading ability_____________________________

letter reversals_________________________________

forgetful ______________________________________

MATH RELATED (Please answer: Yes, No or Not Sure)

Problems with math:

computation_________________________________

concepts____________________________________

word problems ________________________________

poor logic ____________________________________

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. Yet, she reserves the right to make recomendations of any traditional or alternative programs, that she (or one of our associates) has investigated and believes, may be of benefit to the family for them to further investigate and determine how it might apply, or not, in their particular situation. 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 Center For Neuro Development, nor those trained by or who might be employed or associated with it, assume any responsibility or liability for the client and how they might use our program recommendations.

I, as the parent, guardian, or client, assume sole responsibility for my actions and implementation of these recommendations.

I further agree to hold any and all parties associated with the Center For Neuro Development legally faultless concerning these recommendations.

Signature ____ Date ___________________________

Signature ____ Date ___________________________