

CLIENT'S NAME _____ AGE _____ CHAPTER _____

PARENTS OR SPOUSES NAME(S) _____

ADDRESS _____ PHONE (_____) _____

CITY _____ STATE _____ COUNTRY _____ ZIP _____

CELL (_____) _____ CLIENT'S EMAIL _____

MOTHER'S EMAIL _____ FATHER'S EMAIL _____

TODAY'S DATE _____ DATE OF LAST EVALUATION _____ LAST EVALUATION DONE BY _____

PLEASE BRING A PICTURE IF WE HAVE NOT HAD A CURRENT ONE IN THE PAST YEAR.

1. What percentage of the client's total program has been accomplished since the last evaluation? _____
(Example: if your program has 10 activities with frequencies of 4 and you generally get in 2 sequences a day, your percentage would be 50%. If you are only getting these 2 sequences accomplished 4 days per week, your % would be 40%)

Please list time periods in which program is generally accomplished.

____ Morning Afternoon - ____ 12 noon-3 pm or ____ 3 pm-6pm ____ Evening

How pleased have you been with your program implementation on a scale of 1-10? _____

Please list those who are assisting with program implementation:

____ Self ____ Mother ____ Father ____ School teacher or aid

____ Other – please list _____

Are there any parts of the program that you have not been able to accomplish?

2. What specific changes are you seeing?

3. Indicate schools being attended, class, classifications, etc., and/or employment or status:
How would you rate the school program? Scale 1-10 _____

4. List any specific health or sleep problems that have occurred since the last evaluation:

Seizure Disorder _____

5. Please list specific doctors and therapists with whom you are presently working:

<u>Name</u>	<u>Area of attention</u>	<u>Effectiveness (1-10)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. List any medications and what they are prescribed for, as well as any dietary supplements which the client is receiving:

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

7. Are you currently using the services of a nutritional or holistic practitioner? ____ Yes ___ No
If yes...

Name or clinic _____

Address _____

Telephone _____ How long have you been utilizing these services? _____

What is the client's current health status? _____

8. Indicate any specific diet, or dietary limitation:

9. Please list any specific problems or concerns

10. A. Hearing/Auditory Function. D.S.A.'s (Debilitating Sensory Addiction)

Auditory processing or digit span ____ Forward ____ Reverse ____ Other

Describe any issues or concerns related to hearing and auditory function:

Describe any D.S.A.'s/self-stimulatory auditory behaviors your child may be engaged in and how often they occur:

B. Sight/Visual Function, D.S.A.

Visual processing or digit span _____ Forward _____ Reverse _____ Other

Describe any issues or concerns related to vision and visual function:

Describe any D.S.A.'s/self-stimulatory visual behaviors your child may be engaged in and how often they occur:

C. Taste, Smell, Tactility, D.S.A.s

Describe any issues or concerns related to taste, smell or tactility:

Describe any D.S.A.'s/self-stimulatory behaviors related to these areas that your child may be engaged in and how often they occur:

D. Gross Motor

E. Fine motor, self help, writing, typing, etc.
