

Thank you for requesting an **ADULT** application package. We look forward to getting to know your family and providing you with our unique services.

To get started with the NACD program, you must complete these steps:

1. Read the forms enclosed in this application package. They explain important information about how to participate in the NACD program.
 - How to Schedule an Appointment
 - NACD Service Locations
 - Membership Schedule
 - NACD Chapters and How They Work
2. Fill out and sign the following forms enclosed in this application package.
 - Client History
 - Payment Authorization
 - Confidentiality Agreement
3. Return your completed application and letter of endorsement (optional), along with the deposit for your first evaluation (see Membership Schedule) to:

NACD National Headquarters
5492 S 500 E
Washington Terrace, UT 84405
Email: pam@nacd.org

The application takes 3-4 weeks to process. A representative will call you regarding your acceptance.

For more information about NACD (including complete descriptions of services, current chapter locations, journal articles, family testimonials, etc.), please visit our website at:

www.nacd.org



Thank you for your interest in the National Association for Child Development.

NACD is an organization of dedicated parents and professionals founded in 1979 by internationally recognized educator and lecturer Robert J. Doman, Jr. NACD has developed a unique and effective approach to enhancing the development and function of children and adults. NACD believes in the innate potential of every child and works with families to help every child reach their full potential.

Over the years we have seen educational and health-related fields become more and more compartmentalized. Treatment approaches have come to be driven more by symptom and label, rather than by cause and an appreciation of the uniqueness and totality of the individual.

In contrast, NACD has created an approach to human development, the achievement of human potential, and the remediation of developmental, educational, and neurological problems that is based upon the gestalt of the individual. NACD's Neurodevelopmental Approach utilizes a neurologically based, targeted, eclectic treatment methodology.

The efficacy of NACD's Neurodevelopmental Approach has been demonstrated with clients with functions ranging from comatose to gifted and from infant to geriatric. NACD has worked with children with labels including, but not limited to, ADD, ADHD, LD, Dyslexia, Developmentally Delayed, Brain Injured, Cerebral Palsy, Down Syndrome, PDD, and Autism.

NACD has centers located around the country and internationally, where families bring their child once every four months. At that time our staff evaluates the child, and an individualized program is designed to meet the child's developmental and educational needs. The parents are then trained in the implementation of the program. NACD's program is carried out within the child's home or school, under the guidance and support of the NACD team of professionals.

If we can help you schedule an appointment with NACD, please feel free to contact us.

Sincerely,

NACD Staff
info@nacd.org

HOW TO SCHEDULE AN APPOINTMENT

Any family interested in receiving an NACD TDI Targeted Developmental Intervention® program is required to complete the following steps:

- Complete the contents of the application package in its entirety.
- Obtain letters of endorsement from current or past NACD families, if possible.
- Return the completed application package along with your deposit for the Initial Evaluation to the National Office (email or US mail accepted).
- Families are required* to have access to high-speed internet to view program videos, along with an active email address. If you don't have high-speed internet access at home, you will need to have an alternate plan, such as going to your local library, using a spouse's computer at work, taking a laptop to an establishment that offers internet access, or asking a neighbor, friend or family member if you can view program video clips at their home.

***NOTE: If you have any religious or cultural reasons that limit or restrict your access to or ability to use the internet, NACD can make provisions so that internet access is not required.**

Our office will contact you approximately 3–4 weeks after your application package and deposit have been received and reviewed. At that time, NACD will conduct a preliminary interview prior to your acceptance into the program.

NACD SERVICE LOCATIONS

NATIONAL OFFICE

5492 South 500 East • Washington Terrace, UT 84405
801-621-8606
info@nacd.org

CURRENT CHAPTER LOCATIONS

Our ability to travel to these chapters and conduct evaluations there is dependent upon the local families being able to build and maintain the client base. NACD does not guarantee that we will be able to continue traveling to a particular chapter, although we will make every feasible effort to do so.

Arizona

Phoenix

Georgia

Atlanta

Pennsylvania

Greater Philadelphia area

Arkansas

Little Rock

Illinois

Chicago

Texas

Greater Dallas area

California

Greater Los Angeles area

Missouri

St. Louis

Texas

Greater Houston area

California

Greater Bay area

New York/New Jersey

Parsippany

Utah

Ogden/SLC/Provo & St. George

Colorado

Denver

Ohio

Cincinnati

Virginia

Charlottesville

Florida

Orlando

Washington

Seattle

INTERNATIONAL CHAPTER LOCATIONS

London, England New Delhi, India
Sydney, Australia Bucharest, Romania

NACD FAMILY MEMBERSHIP SCHEDULE - USA/INTERNATIONAL

JANUARY 2018

Family Membership Program

01/26/18: NACD has received a donation earmarked specifically to aid new families who wish to join NACD. If you need the assistance the initial fee is reduced from \$950 to \$450. This will only be available for a limited time and must be requested.

Initial Evaluation: \$950†
Deposit: \$450*

NACD is a membership organization. Following the initial evaluation monthly membership dues of \$260 will be processed on the first of every month.**

Monthly Family Membership includes:

- Interview with the family and review of client's history
- Evaluation of the primary family member
- Design of an individualized **TDI Targeted Developmental Program™**
- Training videos and materials in the implementation of the program for parents and caregivers
- Access to the Family Portal, which contains a record of all evaluations, programs, program instructions, video library of the client and other critical information
- Ongoing coach support and access to your TDI specialist who can answer questions, review videos, and make ongoing program enhancements as needed, through email, phone and Skype
- Live or Skype re-evaluations and program enhancements every 4 months
- Availability to have assessments and TDI programs designed for additional family members at a greatly reduced fee

Additional Family Members

Initial Evaluation: \$250
Deposit: \$150*

NACD encourages families to work together so that everyone is working toward achieving their potentials, parents and sibling alike. Additional family members may receive an evaluation and TDI Program for an initial fee of \$250, then for an additional monthly membership fee of \$50 receive **ongoing four-month evaluations**. We also provide the opportunity for any additional family member to come when and as needed for a fee of \$250 per evaluation. Deposit of \$150 is required to hold the evaluation slot.

Returning Families: \$650
Deposit: \$350*

This fee reactivates the family membership and funds their new evaluation. The monthly membership becomes reactivated. This is only available for families who are returning after 12 months or more.

Additional Services: \$250

Additional services will be charged at the rate of \$250 per hour for phone or Skype meetings with schools or therapists, as well as for letters or reports. Membership does not cover specific materials that may be recommended on program activities.

Rescheduling Fee: \$75

A fee of \$75 will be charged for any evaluation this is rescheduled two weeks or less before the appointment.

† Partial scholarships may be available. Please contact the Main Office for an application.

*Deposits are due when the appointment is scheduled. Two weeks prior to the appointment the balance will be collected via payment authorization. A fee of \$25 will be charged to any credit/debit card account not clearing the charges. Deposits will be refunded in full if the appointment is cancelled at four weeks prior to the scheduled appointment day.

**The monthly membership is charged to the member's credit card or checking account on the first day of each month. Monthly membership continues until the family chooses to stop NACD services and notifies NACD in writing or email of their desire to terminate services. Monthly membership fees are not refundable.

All fees are for stated services and are subject to change without notice.

NACD CHAPTERS AND HOW THEY WORK

IMPROVING LIVES AND IMPACTING COMMUNITIES

NACD works with some of the best families in the world. When these families get together to change how their communities view children with delays, they can make a resounding difference. How does this work? It works best when NACD parents join forces with other NACD parents within a geographic area to effect change.

NACD is able to serve the most children at our international headquarters in Utah. However we do have a number of local chapters where we work with parent groups in that location. Our ability to travel to these chapters and conduct evaluations there is dependent upon the local families being able to build and maintain the client base. NACD does not guarantee that we will be able to continue traveling to a particular chapter, although we will make every feasible effort to do so.

As NACD evaluators travel to various branches, in addition to holding individual evaluations, they are able to meet with families to discuss new approaches and changes within NACD. They also have the opportunity to discuss ways in which families can have an impact on their communities. Most ideas in this regard actually come from the parents who know their communities the best. The meetings serve as an opportunity to share ideas and build networks among the families. They also serve as an opportunity to allow parents considering NACD and interested professionals, such as teachers and therapists, learn more about us.

What do parents in an NACD chapter do to change their community?

Parents look for opportunities to educate others within their community about the potential of children who have been labeled with delays. They spread the word to other families who are seeking help with their children. They assist in organizing meetings and participate in these meetings. They network with local support groups and organizations in order to educate them regarding new approaches to working with children with delays.

These efforts have a ripple effect that does impact the community, the schools, the professionals, service organizations, and more.

An excellent example of this is our St. Louis chapter parent group. This powerful group of parents has brought in many new families and have located and participated in conferences, association meetings, and parent groups in their community. They have spread the word of new interventions and provided a clearer understanding of what causes delays and how to fix them. They continue to make their voices heard within their community. What have been the results of their efforts? They have expanded their chapter. They have educated many new families, teachers, therapists and physicians in their community. They have made an impact on agencies within their state, such as the Department of Mental Health.

How do parents in NACD chapters help each other?

One of the many benefits of the Parent Meeting is that it allows parents to meet each other face to face and get to know each other. Talking with and getting to know other NACD families brings a welcome sense of community. You are not in this alone! Things parents have shared to help each other include local physicians who have been helpful, sources of less expensive organic foods, babysitters, places to find materials locally, sources of supplements locally, fun activities to do with kids locally, volunteers and more. Some chapters have set up Mom's Nights Out. Some have organized picnics and barbecues. Groups have set up directories to make contacting each other and communicating easier. Many parents find this additional support invaluable in moving forward with their NACD program.

Building and maintaining your chapter

NACD is a powerful group of families and staff working together to effect change in individual children and in communities. In order for evaluators to help the most children, we continue to build our base office in Utah. Our ability to work with children in chapters is based entirely on the ability of parents in a geographic area to build a big enough base to make and keep that chapter viable. We salute our marvelous parent groups who are working together to educate their communities, bring together new families in search of help, and support each other in moving forward with their children. We also salute parents whose children are seen at the base offices who also work to be voices in their communities to educate others.



5492 South 500 East
Washington Terrace, UT 84405

**ADULT
APPLICATION PACKAGE
EFFECTIVE MARCH 2014**

CLIENT'S NAME

Attach a small photo here

APPLICATION – ADULT

Today's Date _____ Form is completed by: Self Parent Guardian (please check one)

Client's Name _____

Date of Birth (mth/day/year) _____

Address _____

Phone (international families please include the country code)

City _____

Home _____

State _____ Zip Code _____

Work _____

Country _____

Cell _____

Occupation _____

Primary Email _____

Mailing Address (if different from above) _____

Skype Name _____

Client lives with Self Spouse Parent Guardian Other _____

Was the client adopted? yes no If yes, at what age? _____

Gender _____ Male _____ Female

Spouse/Parent/Guardian's Name _____

Date of Birth _____

Address _____

Phone (international families please include the country code)

City _____

Home _____

State _____ Zip Code _____

Work _____

Country _____

Fax _____

Education completed _____

Cell _____

Occupation _____

Email _____

Children Information

<u>Children</u>	<u>On NACD</u>	<u>Children</u>	<u>On NACD</u>
Name	Age	Name	Age
<u>Program?</u>		<u>Program?</u>	
Name _____	Age _____	Name _____	Age _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	Age _____	Name _____	Age _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	Age _____	Name _____	Age _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	Age _____	Name _____	Age _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

At what location would you like your appointment scheduled? _____

Office Use _____ _____

How did you become aware of NACD?

- NACD Family (Please specify) _____
- Professional Group (Please specify) _____
- Publication (Please specify) _____
- Internet (Please specify) _____
- Other (Please describe) _____

Have you listened to Guide to Child Development and Education "Miracles of Child Development" CD series by Robert J. Doman Jr.?

Client yes no Spouse yes no Parent/Guardian yes no

MEDICAL HISTORY

Family Physician _____ Telephone _____

Address _____

Client's birth weight _____ lbs _____ oz. Length of pregnancy _____

Complications during pregnancy and/or delivery? yes no If yes, please describe _____

Has the client ever had a head/brain injury? yes no If yes, please describe _____

_____ Date(s) _____

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

Date	Examined by	Diagnosis	Recommendations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries? yes no Please describe _____

Seizures? yes no Frequency of Seizures _____ Length _____

Type(s) _____

Currently taking seizure medication? yes no List medication(s) _____

Seizure medications taken previously? yes no List medication(s) _____

Currently taking other medications? yes no List medication(s) _____

Are there any medical problems which place limitations on physical activity, etc.? yes no List _____

Broken limbs? yes no List specifics _____

HEALTH

Was the client nursed? yes no If yes, until what age? _____

Describe the client's diet _____

	Excessive	Daily	Weekly	Rarely	Never
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Colorings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White Flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Allergies? yes no If yes, please describe _____

Does the client have a history of colds or sinus congestion? yes no
Does the client have a history of ear infections? yes no
If yes, which ears have been affected? left right both
How many? _____ Over what period of time? _____

Does the client have Tinnitus? yes no

If yes, which ears have been affected? left right both

Is the Tinnitus continuous intermittent

Does the client have a hearing loss? yes no

If yes, which ears have been affected left right both

Degree of hearing loss _____

Does the client have hypersensitive hearing? yes no

Has the client had a tympanogram, audiogram, ABR? yes no

If yes, what were the results _____

Has the client had an eye examination? yes no

Does the client wear glasses or contact lenses? yes no

If yes, what is the prescription _____

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

- near sighted far sighted astigmatism amblyopia
- strabismus macular problems glaucoma cataracts
- nystagmus blind cortical blindness other

Has the client ever received vision therapy? yes no Please comment _____

Sleep times from _____ to _____

Naps from _____ to _____

Physical activity

Types of activities

Duration

Days per week

Types of activities	Duration	Days per week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the client currently seeing a specialist? yes no

- Neurologist Occupational therapist Other _____
- Psychiatrist Physical therapist _____
- Psychologist Speech therapist _____
- Orthopedist EEG Neurofeedback therapist _____
- Cardiologist Vision therapist _____
- Osteopathic Physician Music therapist _____
- Naturopathic Physician AIT, Tomatis, Sound therapist _____
- Chiropractor Counselor _____
- Tutor _____

Other health problems? yes no List _____

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	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	avoidance behavior	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
short attention span	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty following directions	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
hyperactive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with parents	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
hypoactive (low activity level)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with siblings	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
rigid or inflexible	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with teachers	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
impulsive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with peers	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
temper tantrums	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive to sound	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
sucks thumb	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive to touch	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
few or no friends	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive to odors	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
socially immature	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	tics	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
perseverating (talking on a topic)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	phobias	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
low frustration level	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	emotional	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
overreacts	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
destructive behavior	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	high tolerance for pain	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
aggressive behavior	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	low tolerance for pain	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
cyclical behavior (good days/bad days)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	compliant	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
academic output (good days/bad days)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	cooperative	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
achievement		obedient	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
(high in some cases, but low others)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	organized	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
disorganized	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	flexible	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
likes competitive games	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	social	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

PHYSICAL MOTOR SKILLS (please check problem areas)

low muscle tone

walking

balance

high muscle tone

running

other _____

coordination

athetoid movement

crawling (on stomach)

ataxic

creeping (on hands and knees)

weak

HAND PREFERENCE

	Right	Mixed	Left
writing	_____	_____	_____
eating	_____	_____	_____
throwing	_____	_____	_____
brushing teeth	_____	_____	_____
combing hair	_____	_____	_____
other _____	_____	_____	_____
_____	_____	_____	_____

LANGUAGE AND READING SKILLS

articulation problems	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure		
stuttering	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	letter reversals	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
aphasia	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	mirror writing	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
poor pencil grasp	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	right, left confusion	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
sloppy writing	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	poor judge of time	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
poor reading ability	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	poorly organized	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
difficulty copying from a blackboard	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure		

MATH RELATED (check areas of concern)

computation	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	word problems	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
concepts	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	poor logic	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

COGNITIVE (check areas of concern)

visualization	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	short-term Memory	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
long-term memory	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	forgetful	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
conceptualization	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure		

DEVELOPMENTAL HISTORY

Age.....

crawled (on stomach)	_____ years	_____ months
crept (on hands and knees)	_____ years	_____ months
walked	_____ 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

Does the client enjoy watching television? yes no

Speech and language problems? yes no

Does the client enjoy being read to? yes no

Fine motor problems? yes no

Does the client enjoy reading books? yes no

Gross motor problems? yes no

Does the client bed wet? yes no

List client's preferred free time activities

EDUCATIONAL HISTORY

Present educational placement

Days per week _____

Hours of attendance _____

Home School Private Charter Behavioral Public college/university Special _____

List all schools/programs attended, years attended and grade(s) completed.

List any educational problems (past or current)

List any labels, classifications, or educational diagnoses (past or current)

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

List any classes/lessons the client is enrolled in (musical, physical/sports, art, languages, etc.)

Are there any events which may be currently affecting the client adversely? yes no

Please describe _____

GOALS AND PLANS

What are your goals and expectations?

Professionally: _____

Academically: _____

Personally: _____

Who will implement the program? _____

Daily length of time they can work with client _____

Daily length of time others can work with client _____

The National Association for Child Development is an organization of parents and professionals dedicated to assisting individuals in the achievement of their innate potentials. Program recommendations are not medical, therapeutic, or psychological prescriptions. Program recommendations are offered for the client and families' review, investigation and education. Application of said procedures is the responsibility of the client and family. Robert J. Doman, Jr., (founder), is an educator. He does not, nor is he licensed to, practice medicine. If medical or other licensed professional advice is needed, the family is urged to consult a licensed physician or other licensed professional.

I acknowledge that I have read and completed this information to the best of my knowledge and ability, and that I understand that neither NACD nor those trained by or employed by NACD are assuming responsibility or liability for the client, and that I, as parent, guardian or client, assume full responsibility.

Signature _____ Date _____

Signature _____ Date _____

Client Name _____

Commitment and Confidentiality Agreement

This Agreement is between the National Association of Child Development (“NACD”) and the client identified below.

The National Association for Child Development (NACD) is an international organization that exists to gather, evaluate, and disseminate information and procedures relative to human development.

We empower parents with the specific expertise to assume primary responsibility for their children's maximum growth and development.

NACD dedicates its time to parents who are committed to helping their children. As such, we are limited in the number of families we can serve.

Development and neurological organization is an ongoing process. It takes hard work, a great deal of time and energy. All of our families have committed their time and energy to ongoing education through the evaluation process.

Your commitment is important to your child's progress.

- *We the undersigned understand the commitment NACD has made to assist parents in helping their children realize their fullest potential.*
- *We commit to working with other chapter members to raise awareness of NACD in our community and to help maintain a large enough base to make and keep our chapter viable.*
- *We commit to doing our best in using the knowledge gained to help our child work toward his/her fullest potential through the use of the NACD program designed for our child.*
- *We understand that we are required* to have an active email account.*
- *We understand that we will need high-speed internet* to access program videos. If we don't have high-speed internet access at home, we will have an alternate plan, such as going to our local library, using a spouse's computer at work, taking a laptop to an establishment that offers internet access, or asking a neighbor, friend or family member if we can view my program video clips at their home.*
- *To meet the specific needs of our child, we agree to meet the evaluation requirements by traveling quarterly to our assigned NACD location.*
- *If we should break this commitment, please give our appointment slot to another family. We understand this will drop us from NACD's caseload. Should we wish to return, we understand we will be put on the National waiting list to return as a new client.*

***NOTE: If you have any religious or cultural reasons that limit or restrict your access to or ability to use the internet, NACD can make provisions so that internet access is not required.**

NACD will create an individualized TDI Targeted Developmental Intervention® program for my child that will be made available to me via the internet. The information contained on these videos is highly confidential and valuable proprietary information of NACD.

In consideration of the services provided by NACD, we agree as follows:

- *We understand that the information provided to us by NACD is highly confidential and valuable proprietary information of NACD.*
- *We agree that we will not copy or share any of the information provided to us by NACD with any third party unless they are directly involved with treatment and care of our child.*
- *We understand that the information provided to us is specific to the needs of our child and agree that it will only be used for our child's personal, noncommercial use. We agree that we will not use the information or allow it to be used for or by any other person.*
- *We understand that if we share this information with others, or allow it to be used by others, we will cause irreparable harm to NACD and will be liable to NACD for any resulting damages.*

Name of Client: _____

Name of Parent(s): _____

Address: _____

Signature: _____

Date: _____

Email Address: _____

NACD INITIAL EVALUATION & PROGRAM FEE PAYMENT AUTHORIZATION

Client Name: _____

We understand that the initial evaluation and monthly membership fees are non-refundable.

We understand that the first day of the month, after our Initial Evaluation, our credit/debit card or checking account will be charged the monthly program fee the first of each month, until such time as we choose to officially stop receiving services and notify NACD in writing. We understand that if our credit/debit card does not clear that our secondary account will be charged. If neither clears there may be a \$25.00 fee.

If fees are to be paid by a second party, we understand that if services are provided and second party does not pay fees, we are personally responsible for payment of those fees.

I authorize the National Association for Child Development, Inc. ("NACD") to charge my account listed below for all fees and charges incurred as a result of the goods and services provided to me by NACD. My signature below will be considered to have been made on the applicable account voucher, and I authorize NACD to fill out and sign the voucher on my behalf. If NACD is unable to collect the assessed fees and charges from my account, I agree to pay NACD such amounts upon demand. If I fail to do so, I will pay interest to NACD on the unpaid amounts from the date due until the date paid at the rate of one and one-half percent (1.5%) per month and all of the costs of collection, including reasonable administrative fees, attorneys' fees, and costs.

Responsible Party: _____

Street Address: _____ **Zip/Postal Code:** _____

PRIMARY ACCOUNT

EFT Personal Business Savings Checking

Name on Account: _____ **Name of Institution:** _____

Account Number: _____ **Routing Number:** _____

Credit/Debit Card VISA Mastercard Discover AMEX

Name as it Appears on Card: _____ **CVC#:** _____

Credit/Debit Card Number: _____ **Exp. Date:** _____

SECONDARY ACCOUNT

EFT/CHECKING Personal Business Savings Checking

Name on Account: _____ **Name of Institution:** _____

Account Number: _____ **Routing Number:** _____

Credit/Debit Card VISA Mastercard Discover AMEX

Name as it Appears on Card: _____ **CVC#:** _____

Credit/Debit Card Number: _____ **Exp. Date:** _____

SIGNATURE (REQUIRED)

Signature

Signature (Print)

Date

Email Address

All fees are for stated services only and are subject to change without notice.