

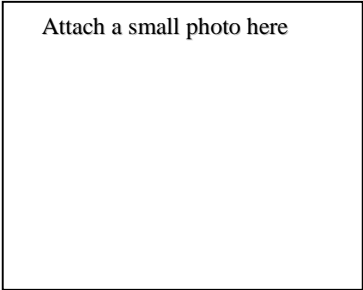


**549 25TH STREET
OGDEN, UT 84401-2422**

**CHILD APPLICATION
NACD CENTER FOR
SPEECH AND SOUND**

EFFECTIVE FEBRUARY 2011

CHILD'S NAME



CLIENT HISTORY – Child Center for Speech and Sound

Today's Date _____ Form is completed by: Parent Guardian Other _____

Client's Name _____ Date of Birth (mth/day/year) _____

Address _____ Phone (international families please include the country code) _____

City _____

State _____ Zip Code _____ Primary E-mail _____

Country _____

Mailing Address (if different from above) _____

Client lives with Both Parents Mother Only Father Only Guardian Other _____

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

Father's Name _____

Address _____

City _____

State _____ Zip Code _____

Country _____

Education completed _____

Occupation _____

Date of Birth (mth/day/year) _____

Phone (international families please include the country code)

Home _____

Work _____

Fax _____

Cell _____

Email _____

Mother's Name _____

Address _____

City _____

State _____ Zip Code _____

Country _____

Education completed _____

Occupation _____

Date of Birth (mth/day/year) _____

Phone (international families please include the country code)

Home _____

Work _____

Fax _____

Cell _____

Email _____

Guardian/Other Name _____

Address _____

City _____

State _____ Zip Code _____

Country _____

Education completed _____

Occupation _____

Date of Birth (mth/day/year) _____

Phone (international families please include the country code)

Home _____

Work _____

Fax _____

Cell _____

Email _____

Office Use _____

MEDICAL HISTORY

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

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

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

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

Has the client had any of the following:

- Hearing loss yes no Specific testing _____
Specific diagnosis _____
- Ear infections yes no How many? _____ Ages _____
- Middle ear fluid yes no How often ? _____ Ages _____
- Pressure equalizing tubes yes no How many times? _____ Ages _____
- Seizures yes no Please describe _____
- Surgeries yes no Please describe _____
- Head injuries yes no Please describe _____
- Hearing aids yes no Please describe _____
- Cochlear implants yes no Please describe _____

DEVELOPMENTAL HISTORY

List any specific diagnoses: _____

Current therapies: _____

Any previous sound therapy? yes no If yes, please describe: _____

Do you question your child's hearing? yes no If yes, please describe: _____

Are there any sounds that seem to bother your child? yes no If yes, please describe _____

Does your child ever cover their ears? yes no o If yes, please describe _____

Is your child bothered by background sound? yes no If yes, please describe _____

Is your child easily overwhelmed in noisy environments? yes no If yes, please describe _____

Does client demonstrate any of the following:

Please explain any "yes" response

Rate: 1 – 10
(1-mild to 10-severe)

Gross motor delays	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Fine motor delays	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Articulation disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Language delay	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Overly sensitive to sound	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Problems hearing	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Exceptional hearing	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Voice too loud	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Voice sing-song or monotone	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Difficulty listening	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Difficulty attending	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Easily distracted	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Reading problems	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Word-finding problems	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Bed wetting	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
Difficulty wearing headphones	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____

Additional explanation, if needed: _____

GOALS AND PLANS

Please briefly describe your goals and expectations for this program: _____

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 _____