the national association for child development

PROGRAM EVALUATION

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?

_____

_____

_____

_____

_____

_____

_____

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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:

Name	Area of attention	Effectiveness (1-10)

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

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

_____

_____

_____

F. Language, speech, eating/oral motor issues

G. Behavior

H. Academic function

Please list books being used and placement (beginning, middle, end)

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11. Please list each program activity and specific comments relative to problems, changes, etc.

ACTIVITY	COMMENTS

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Signature _____ Date _____

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