the national association for child development

PROGRAM REVIEW

CLIENT'S NAME _____ AGE _____ CHAPTER _____

PARENTS OR SPOUSES NAME(S) _____

ADDRESS _____ PHONE (_____) _____

CITY _____ STATE _____ COUNTRY _____ ZIP _____

CELL (_____) _____ EMAIL _____

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

1. **How happy have you been with your current program on a scale of 1-10?** _____

How would you rate the results you have seen on a scale of 1-10? _____

What specific changes are you seeing? _____

_____

_____

_____

2. **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? _____

_____

_____

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

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

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4. **Indicate any specific diet, or dietary limitation:**

_____
_____
_____
_____
_____

5. **List any specific health problems that have occurred since the last evaluation:**

_____
_____
_____
_____

Seizure Disorder _____
_____
_____

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

Name	Area of attention

7. **Indicate schools being attended, class, classifications, etc., and/or employment or status:**

_____
_____
_____
_____

8. **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%)

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

_____

_____

_____

_____

_____

10. **Please make specific comments in each of the following areas; include changes, concerns, difficulties, etc.**

a. Tactility: _____

_____

_____

_____

b. Auditory function: (Digit Span _____ Reverse Digit Span _____) _____

_____

_____

_____

c. Visual function: (Digit Span _____ Reverse Digit Span _____) _____

_____

_____

_____

d. Manual function: _____

_____

_____

_____

e. Language: _____

_____

_____

_____

f. Mobility _____

_____

_____

_____

g. Behavior: _____

_____

_____

_____

h. Academic function: _____

Italics Book/Page	Math Books No./Page	Reading Books No./Page	Reading Books No./Page
____/____	____/____	____/____	____/____
Reading Books No. /Page	Other Books/Page		Other Books/Page
____/____	____/____		____/____

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

ACTIVITY	COMMENTS

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Name _____

Signature _____ Date _____

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