ADULT APPLICATION

NACD CENTER FOR
SPEECH AND SOUND

EFFECTIVE FEBRUARY 2011

CLIENT’S NAME
CLIENT HISTORY – Adult
Center for Speech and Sound

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) ______________________________________

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 __________________________________ Primary Email __________________________

Children Information

<table>
<thead>
<tr>
<th>Children</th>
<th>On NACD</th>
<th>Children</th>
<th>On NACD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program?</td>
<td>Program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td>Name________________ Age__ ☐Yes ☐No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Office Use __________________________

COPYRIGHT 2011 NACD 2/2011
**MEDICAL HISTORY**

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Examined by</th>
<th>Diagnosis</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you 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 __________

- **Tinnitus (ringing in the ears)**: □ yes □ no
  - Please describe ________________________

- **Vertigo/vestibular problems**: □ yes □ no
  - Please describe ________________________

- **Seizures**: □ yes □ no
  - Please describe ________________________

- **Surgeries**: □ yes □ no
  - Please describe ________________________

- **Head injuries**: □ yes □ no
  - Please describe ________________________

- **Stroke**: □ yes □ no
  - Date __________
  - Please describe ________________________

- **Hearing aids**: □ yes □ no
  - Please describe ________________________

- **Cochlear implants**: □ yes □ no
  - Please describe ________________________

**HEARING/SPEECH/PROCESSING**

List any specific diagnoses: __________________________________________

________________________________________

What are the current concerns that you want to address with our program? __________________________________________

________________________________________
If you answer yes to the following, please describe:

Are you currently receiving treatment for problems related to hearing, processing, or speech/language? □ yes □ no

Have you had any previous sound therapy? □ yes □ no

Do any particular sounds bother you? □ yes □ no

Do you frequently wear headphones? □ yes □ no

Does background sound bother you? □ yes □ no

Do you find it difficult to function or interact in noisy environments? □ yes □ no

Are you easily distracted? □ yes □ no

Do you have trouble focusing or attending? □ yes □ no

Is there anything you don’t like about your voice? □ yes □ no

Do you have any problems with articulation or communication? □ yes □ no

Are you currently using the Simply Smarter System for sequential processing? □ yes □ no If so, what is your auditory digit span?

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 ____________________

COPYRIGHT 2011 NACD
2/2011