549 25TH STREET
OGDEN, UT 84401-2422

ADULT APPLICATION
NACD CENTER FOR SPEECH AND SOUND

EFFECTIVE FEBRUARY 2011

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CLIENT'S NAME

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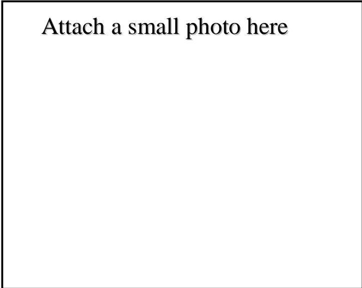
nacd the national association for child development



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 ____________________ Email ____________________

Children Information

Children		On NACD Program?	Children		On NACD Program?
Name ____________	Age ____	☐Yes ☐No	Name ____________	Age ____	☐Yes ☐No
Name ____________	Age ____	☐Yes ☐No	Name ____________	Age ____	☐Yes ☐No
Name ____________	Age ____	☐Yes ☐No	Name ____________	Age ____	☐Yes ☐No
Name ____________	Age ____	☐Yes ☐No	Name ____________	Age ____	☐Yes ☐No

Office Use ____________________

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Client Name ____

MEDICAL HISTORY

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

Date	Examined by	Diagnosis	Recommendations

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? ____

____

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Client Name ____

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 ____________________

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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?

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GOALS AND PLANS

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

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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 ____________________

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