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____________________________________________________ Date of Birth (mth/day/year)__________________________
Address_________________________________________________________
City__________________________________________________________________________________________________________
State ____________ Zip Code ______________ Phone (international families please include the country code)
Country __________________________________________________________
Education completed_______________________________________________ Occupation _____________________________________________
Occupation __________________________________________________________

Mother's Name____________________________________________________ Date of Birth (mth/day/year)__________________________
Address_________________________________________________________
City__________________________________________________________________________________________________________
State ____________ Zip Code ______________ Phone (international families please include the country code)
Country __________________________________________________________
Education completed_______________________________________________ Occupation _____________________________________________
Occupation __________________________________________________________

Guardian/Other Name_______________________________________________ Date of Birth (mth/day/year)__________________________
Address_________________________________________________________
City__________________________________________________________________________________________________________
State ____________ Zip Code ______________ Phone (international families please include the country code)
Country __________________________________________________________
Education completed_______________________________________________ Occupation _____________________________________________
Occupation __________________________________________________________
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:

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>□ yes</th>
<th>□ no</th>
<th>Please explain any “yes” response</th>
<th>Rate: 1 – 10 (1-mild to 10-severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross motor delays</td>
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<tr>
<td>Fine motor delays</td>
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<tr>
<td>Articulation disorder</td>
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<tr>
<td>Language delay</td>
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<tr>
<td>Overly sensitive to sound</td>
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<tr>
<td>Problems hearing</td>
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<tr>
<td>Exceptional hearing</td>
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<td>Voice too loud</td>
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<tr>
<td>Voice sing-song or monotone</td>
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<tr>
<td>Difficulty listening</td>
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<td>Difficulty attending</td>
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<td>Easily distracted</td>
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<tr>
<td>Reading problems</td>
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<tr>
<td>Word-finding problems</td>
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<tr>
<td>Bed wetting</td>
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<td>Difficulty wearing headphones</td>
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</table>

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 _________________