549 25TH STREET
OGDEN, UT 84401-2422

CHILD APPLICATION
NACD CENTER FOR SPEECH AND SOUND

EFFECTIVE FEBRUARY 2011

CHILD'S NAME

the national association for child development

Attach a small photo here

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_____ Phone (international families please include the country code)

City_____ Home_____

State _____ Zip Code_____ Work_____

Country_____ Fax_____

Education completed_____ Cell_____

Occupation _____ Email _____

Mother's Name_____ Date of Birth (mth/day/year)_____

Address_____ Phone (international families please include the country code)

City_____ Home_____

State _____ Zip Code_____ Work_____

Country_____ Fax_____

Education completed_____ Cell_____

Occupation _____ Email _____

Guardian/Other Name_____ Date of Birth (mth/day/year)_____

Address_____ Phone (international families please include the country code)

City_____ Home_____

State _____ Zip Code_____ Work_____

Country_____ Fax_____

Education completed_____ Cell_____

Occupation _____ Email _____

Office Use _____

_____

Client Name _____

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:

Date	Examined by	Diagnosis	Recommendations

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: _____

_____

_____

_____

Client Name _____

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 o 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:

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

Additional explanation, if needed: _____

Client Name _____

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 _____