THE LISTENING PROGRAM®

Client History-Adult

Today's Date _____ Form completed by (check one) ❑ Self ❑ Other

Name _____ Date of Birth _____

Address _____ Home Phone _____

City _____ Work Phone _____

State _____ Zip _____ Fax _____

Country _____ Email _____

Occupation _____ Marital Status Married | Divorced Separated | Single

Mailing Address (if different from above) _____

Spouse / Significant Other / Guardian _____ Date of Birth _____

Address (if different from client's) _____ Home Phone (if different from client's) _____

City _____ Work Phone _____

State _____ Zip _____ Email _____

Country _____

1. Who do you live with?

Name	*Age*	*Name*	*Age*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. How did you become aware of TLP?

❑ Professional Group _____ ❑ Internet _____

❑ Publication _____ ❑ Other _____

3. Developmental History

The client's birth weight _____ lbs. _____ oz. length of pregnancy _____

During the pregnancy, what language(s) did the client's mother speak? _____

Were there complications during the client's mother's pregnancy, labor, and or delivery (maternal health problems, accidents, stress, bed rest, medication, fetal distress, abnormal positioning, cesarean section, use of forceps, vacuum extraction, any other complications)? ❑ Yes ❑ No

If yes, describe _____

_____

_____

_____

Does the client have any remarkable information about any of the following developmental matters?

Feeding history (including nursing)	❑ Yes ❑ No ❑ Not sure	Speech/language development	❑ Yes ❑ No ❑ Not sure
Colic	❑ Yes ❑ No ❑ Not sure	Motor development	❑ Yes ❑ No ❑ Not sure
Activity level during early years	❑ Yes ❑ No ❑ Not sure	Reaction to experiences such as bathing, diaper changes, rocking, positioning (on back, stomach), cuddling	❑ Yes ❑ No ❑ Not sure
Sleep	❑ Yes ❑ No ❑ Not sure		

If any of the above are marked yes, describe below _____

_____

_____

4. Medical / Health History

Family Physician _____ Physician's Work Phone _____

Physician's Address _____

_____

Describe the client's general health. _____

_____

_____

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

Date	Examiner	Diagnosis	Recommendations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the client ever had a traumatic injury? ❑ Yes ❑ No

If yes, describe with dates _____

_____

Has the client ever had any surgeries? ❑ Yes ❑ No

If yes, describe with dates _____

_____

Has the client ever had a seizure(s)? ❑ Yes ❑ No

Date of most recent seizure _____

Frequency of seizures _____ Length of seizures _____

Describe the type of seizures _____

Current seizure medication(s) _____

Previous seizure medication(s) _____

Are there any other medications that the client is currently taking? ❑ Yes ❑ No

If yes, list medications _____

_____

Are there any medical problems which place limitations on physical activity, etc.? ❑ Yes ❑ No

If yes, describe _____

_____

_____

Does the client have any allergies? (other than food allergies listed below) ❑ Yes ❑ No

If yes, describe _____

_____

_____

Does the client have a history of colds or sinus congestion? ❑ Yes ❑ No

If yes, describe _____

_____

_____

Does the client have a history of ear infections? ❑ Yes ❑ No

If yes, which ears have been affected? ❑ Right ❑ Left ❑ Both

How many? _____ Over what period of time? _____

Does the client have tinnitus (ringing in the ear)? ❑ Yes ❑ No

If yes, which ears have been affected? ❑ Right ❑ Left ❑ Both

Is the tinnitus ❑ Continuous ❑ Intermittent

Does the client have hearing loss? ❑ Yes ❑ No

If yes, which ears have been affected? ❑ Right ❑ Left ❑ Both

Describe the degree of hearing loss _____

_____

Does the client have hypersensitive hearing? ❑ Yes ❑ No

If yes, describe _____

_____

Has the client had a tympanogram, audiogram, ABR? ❑ Yes ❑ No

If yes, what were the results? _____

List participation in any of the following programs and results.

❑ AIT "Berard"	❑ Tomatis	❑ DLS
❑ Samonas	❑ Disc Ease	❑ Fast Forword
❑ Earobics	❑ BrainBuilder	❑ Interactive Metronome

Results _____

_____

_____

Has the client been diagnosed with any of the following: (please check)

❑ Near Sightedness	❑ Far Sightedness	❑ Astigmatism	❑ Amblyopia
❑ Strabismus	❑ Macular Problems	❑ Glaucoma	❑ Cataracts
❑ Nystagmus	❑ Blind	❑ Cortical Blindness	❑ Other _____

Does the client wear glasses or contact lenses? ❑ Yes ❑ No How long? _____

If yes, what is the prescription? _____

Has the client ever received vision therapy? ❑ Yes ❑ No

Comments _____

Check any services the client currently receives:

❑ Neurologist	❑ Nutritionist	❑ Vision Therapist
❑ Psychiatrist	❑ Chiropractor	❑ Art Therapist
❑ Psychologist	❑ Tutor	❑ Music Therapist
❑ Orthopedist	❑ Occupational Therapist	❑ AIT, Tomatis, DLS
❑ Cardiologist	❑ Physical Therapist	❑ Counselor
❑ Osteopathic Physician	❑ Speech Therapist	❑ Other _____
❑ Naturopathic Physician	❑ EEG Neurofeedback Therapist	

If being seen on a weekly basis, how many times/sessions a week? _____

Any other health problems not mentioned above? ❑ Yes ❑ No

If yes, describe _____

_____

5. Dietary History

How often does the client consume the following? (check one for each item)

	Excessive	Daily	Weekly	Rarely	Never
Vegetables					
Fruit					
Grain					
Dairy					
Protein					
Fiber					
Sugar					
Artificial Sweeteners					
Artificial Colorings					
White Flour					
Caffeine					
Tobacco					
Alcohol					
Other drugs					

Describe, in detail, the client's current diet.

_____

_____

Describe the client's appetite.

Food Cravings? ❑ Yes ❑ No If yes, what _____

Picky Eater? ❑ Yes ❑ No If yes, describe _____

Overeating? ❑ Yes ❑ No If yes, how often _____

Poor appetite? ❑ Yes ❑ No If yes, describe _____

List any dietary supplements and vitamins that the client takes regularly.

_____

_____

6. Behavior

Are you now or have you ever been concerned about any of the following with regard to this client?

Arousal/energy level	❑ Yes ❑ No ❑ Not sure	Interaction with parents	❑ Yes ❑ No ❑ Not sure
Attention	❑ Yes ❑ No ❑ Not sure	Interaction with siblings	❑ Yes ❑ No ❑ Not sure
Distractibility	❑ Yes ❑ No ❑ Not sure	Interaction with children	❑ Yes ❑ No ❑ Not sure
Activity level	❑ Yes ❑ No ❑ Not sure	Interaction with peers	❑ Yes ❑ No ❑ Not sure
Anxiety	❑ Yes ❑ No ❑ Not sure	Interaction with coworkers	❑ Yes ❑ No ❑ Not sure
Impulsivity	❑ Yes ❑ No ❑ Not sure	Interaction with supervisors	❑ Yes ❑ No ❑ Not sure
Self stimulation	❑ Yes ❑ No ❑ Not sure	Affection/physical contact	❑ Yes ❑ No ❑ Not sure

Rigidity	❑ Yes ❑ No ❑ Not sure	Sensitivity to sound	❑ Yes ❑ No ❑ Not sure
Temper	❑ Yes ❑ No ❑ Not sure	Sensitivity to movement	❑ Yes ❑ No ❑ Not sure
Thumb sucking	❑ Yes ❑ No ❑ Not sure	Sensitivity to touch	❑ Yes ❑ No ❑ Not sure
Friendships	❑ Yes ❑ No ❑ Not sure	Sensitivity to odors	❑ Yes ❑ No ❑ Not sure
Social maturity	❑ Yes ❑ No ❑ Not sure	Phobias	❑ Yes ❑ No ❑ Not sure
Perseveration	❑ Yes ❑ No ❑ Not sure	Emotional reactivity	❑ Yes ❑ No ❑ Not sure
Frustration tolerance	❑ Yes ❑ No ❑ Not sure	Pain tolerance	❑ Yes ❑ No ❑ Not sure
Mood	❑ Yes ❑ No ❑ Not sure	Compliance	❑ Yes ❑ No ❑ Not sure
Destructiveness	❑ Yes ❑ No ❑ Not sure	Cooperation	❑ Yes ❑ No ❑ Not sure
Aggressiveness	❑ Yes ❑ No ❑ Not sure	Obedience	❑ Yes ❑ No ❑ Not sure
Avoidance behavior	❑ Yes ❑ No ❑ Not sure	Organization	❑ Yes ❑ No ❑ Not sure
Following directions	❑ Yes ❑ No ❑ Not sure	Independence	❑ Yes ❑ No ❑ Not sure
On task	❑ Yes ❑ No ❑ Not sure	Forgetfulness	❑ Yes ❑ No ❑ Not sure
Handling change	❑ Yes ❑ No ❑ Not sure	Left/right awareness	❑ Yes ❑ No ❑ Not sure
Handling transition	❑ Yes ❑ No ❑ Not sure	Spatial awareness	❑ Yes ❑ No ❑ Not sure
Interaction with spouse	❑ Yes ❑ No ❑ Not sure	Sense of time	❑ Yes ❑ No ❑ Not sure

Comments _____

_____

How would you describe the client's behavior?

Behavior strengths _____

_____

Behavior weaknesses _____

_____

Have any emotional and/or behavioral disorders been specifically identified? ❑ Yes ❑ No

If yes, describe _____

_____

Is there a family history of emotional or behavioral disorders? ❑ Yes ❑ No

If yes, describe _____

_____

7. Physical/Motor *(check areas of concern)*

❑ Low muscle tone	❑ Coordination	❑ Balance
❑ High muscle tone	❑ Walking	❑ Gross motor
❑ General physical condition	❑ Running	❑ Fine motor

8. Hand Preference			
Writing	❑ Right ❑ Mixed ❑ Left	Brushing teeth	❑ Right ❑ Mixed ❑ Left
Eating	❑ Right ❑ Mixed ❑ Left	Combing hair	❑ Right ❑ Mixed ❑ Left
Throwing	❑ Right ❑ Mixed ❑ Left	Gesturing	❑ Right ❑ Mixed ❑ Left
Cutting with scissors	❑ Right ❑ Mixed ❑ Left		

9. Speech/Language and Reading *(check areas of concern)*			
Articulation	❑ Yes ❑ No ❑ Not Sure	Phonemic awareness	❑ Yes ❑ No ❑ Not Sure
Fluency	❑ Yes ❑ No ❑ Not Sure	Decoding	❑ Yes ❑ No ❑ Not Sure
Word finding	❑ Yes ❑ No ❑ Not Sure	Reading aloud	❑ Yes ❑ No ❑ Not Sure
Expressive language	❑ Yes ❑ No ❑ Not Sure	Fatique while reading	❑ Yes ❑ No ❑ Not Sure
Receptive language	❑ Yes ❑ No ❑ Not Sure	Written language comprehension	❑ Yes ❑ No ❑ Not Sure
Letter recognition	❑ Yes ❑ No ❑ Not Sure		

Describe the client's voice. (monotone, choppy, flat, expressive)? _____

_____

10. Writing *(check areas of concern)*			
Pencil grasp	❑ Yes ❑ No ❑ Not Sure	Left/right confusion	❑ Yes ❑ No ❑ Not Sure
Legibility	❑ Yes ❑ No ❑ Not Sure	Letter reversals	❑ Yes ❑ No ❑ Not Sure
Copying near point	❑ Yes ❑ No ❑ Not Sure	Discrepancy between written language and verbal expression	❑ Yes ❑ No ❑ Not Sure
Copying far point	❑ Yes ❑ No ❑ Not Sure		

11. Math *(check areas of concern)*			
Math facts	❑ Yes ❑ No ❑ Not Sure	Problem solving	❑ Yes ❑ No ❑ Not Sure
Concepts	❑ Yes ❑ No ❑ Not Sure	Number recognition	❑ Yes ❑ No ❑ Not Sure
Computation	❑ Yes ❑ No ❑ Not Sure	Counting	❑ Yes ❑ No ❑ Not Sure

12. Cognition *(check areas of concern)*			
Short-Term Memory	❑ Yes ❑ No ❑ Not Sure	Problem solving	❑ Yes ❑ No ❑ Not Sure
Long-Term Memory	❑ Yes ❑ No ❑ Not Sure	Conceptualization	❑ Yes ❑ No ❑ Not Sure
Sequencing	❑ Yes ❑ No ❑ Not Sure	Visualization	❑ Yes ❑ No ❑ Not Sure
Organization	❑ Yes ❑ No ❑ Not Sure	Reasoning	❑ Yes ❑ No ❑ Not Sure

13. Education

List all schools/programs attended, years attended, and grade(s) completed.

_____

_____

List all schools/programs currently attending.

_____

_____

List any educational problems. *(Past or Current)*

_____

_____

List any labels, classifications, or educational diagnoses. *(Past or Current)*

_____

_____

List any exceptional abilities including academic, athletic, performing arts, visual/spatial, public speaking, etc.

_____

_____

List any other classes/lessons in which client is enrolled.

_____

_____

14. Current Lifestyle

Describe the client's current activity level.

❑ Unusually low ❑ Normal ❑ Unusually high ❑ Inadequately regulated

Does the client engage in daily physical activity? ❑ Yes ❑ No

Types and duration of activities _____

_____

_____

What is the client's current sleep pattern?

Sleeps from _____ to _____ Naps from _____ to _____

How much time does the client spend doing the following activities on an average day?

Job related work at home _____

Conversing with family members _____

Talking on the phone _____

Outdoor activities _____

Video/computer games _____

Computer _____

Socializing with peers _____

Television _____

Exercising _____

Relaxing _____

Reading _____

Listening to music _____

How does the client spend most of his/her time?

_____

_____

How much unstructured time is in the client's daily schedule?

_____

What type(s) of music does the client listen to?

_____

Does the client like to sing? ❑ Yes ❑ No

Does the client play any instruments? ❑ Yes ❑ No

If yes, what? _____

What activities does the client enjoy most?

_____

_____

How much time is the television on in the client's home?

_____

Are there any activities that the client refuses to do?

_____

_____

What are the client's family/household responsibilities?

_____

_____

15. Goals and Plans

What are your goals and expectations?

_____

_____

Who will implement the program?

_____

The Listening Program (TLP) is for educational purposes only. TLP has not been reviewed by the FDA and no medical claims of any kind whatsoever are made concerning its use or result.

Name _____ Relationship to client _____

Signature _____ Date _____