THE LISTENING PROGRAM®

Client History-Child

Today's Date _____ Form completed by (check one) ❑ Parent ❑ Guardian

Child's Name _____ Date of Birth _____

Address _____ Home Phone _____

City _____ Work Phone _____

State _____ Zip _____ Fax _____

Country _____ Email _____

Mailing Address (if different from above) _____

Child lives with (check one) ❑ Parent(s) ❑ Guardian ❑ Other _____

Was the child adopted? (check one) ❑ Yes ❑ No If yes, at what age? _____

Father's Name _____ Date of Birth _____

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

City _____ Work Phone _____

State _____ Zip _____ Fax _____

Country _____ Email _____

Education Completed _____ Occupation _____

Mother's Name _____ Date of Birth _____

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

City _____ Work Phone _____

State _____ Zip_____ Fax _____

Country _____ Email _____

Education Completed _____ Occupation _____

Guardian's Name _____ Date of Birth _____

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

City _____ Work Phone _____

State _____ Zip _____ Fax _____

Country _____ Email _____

Education Completed _____ Occupation _____

1. Family Information

Family Member or Live-In Care Giver	*Age*	*Currently using TLP*	*Family Member or Live-In Care Giver*	*Age*	*Currently using TLP*
Name _____	_____	❑ Yes ❑ No	Name _____	_____	❑ Yes ❑ No
Name _____	_____	❑ Yes ❑ No	Name _____	_____	❑ Yes ❑ No
Name _____	_____	❑ Yes ❑ No	Name _____	_____	❑ Yes ❑ No
Name _____	____	❑ Yes ❑ No	Name _____	_____	❑ Yes ❑ No

2. How did you become aware of TLP?

❑ Professional Group _____ ❑ Internet _____

❑ Publication _____ ❑ Other _____

3. Developmental History

Child's birth weight _____ lbs. _____ oz. length of pregnancy _____

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

Were there complications during pregnancy (maternal health problems, accidents, stress, bed-rest, medication, any other complications)? ❑ Yes ❑ No

If yes, describe _____

_____

_____

Were there complications during labor and/or delivery (fetal distress, abnormal positioning, cesarean section, use of forceps, vacuum extraction, any other complications)? ❑ Yes ❑ No

If yes, describe _____
_____
_____

Was the child nursed? ❑ Yes ❑ No If yes, until what age? _____

Was there anything remarkable about the child's early feeding history? ❑ Yes ❑ No

If yes, describe _____
_____
_____

Describe the child's activity level during his/her early years.

❑ Unusually low ❑ Normal ❑ Unusually high ❑ Inadequately regulated

Describe _____
_____

Describe the child's sleep pattern during his/her early years.

_____

Did the child have colic as an infant? ❑ Yes ❑ No If yes, for how long? _____

How would you describe the child's early speech and language development? (Typical, Slow, Advanced)

Describe _____
_____
_____

Describe the child's early sensory motor skills. _____
_____
_____

Did the child tolerate bathing? If not, describe what his/her reaction(s) were.

_____

Did the child enjoy being rocked, touched, cuddled, etc.?

Describe _____
_____

At what age did the child accomplish the following milestones?

Crawling (on stomach)	Yrs/Mos _____	First word	Yrs/Mos _____
Creeping (on hands and knees)	Yrs/Mos _____	Two words together	Yrs/Mos _____
Walking	Yrs/Mos _____	3-4 word phrases	Yrs/Mos _____
Toilet training	Yrs/Mos _____	Sentences	Yrs/Mos _____
Babbling	Yrs/Mos _____	Conversational language	Yrs/Mos _____

4. Medical / Health History

Family Physician _____ Physician's Work Phone _____

Physician's Address _____
_____

Describe the child's general health. _____
_____
_____

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

Date	Examined by	Diagnosis	Recommendations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has this child ever had a head or brain injury? ❑ Yes ❑ No

If yes, describe with dates _____
_____

Has this child ever had any surgeries? ❑ Yes ❑ No

If yes, describe with dates _____
_____

Has this child ever had a seizure(s)? ❑ Yes ❑ No

Frequency of seizures _____ Length of seizures _____

Describe the type of seizures _____

Is this child currently taking seizure medication? ❑ Yes ❑ No

If yes, list medications _____

Has the child ever taken seizure medication? ❑ Yes ❑ No

If yes, list medications and when taken _____
_____

Are there any other medications that the child 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 child have any allergies? (other than food allergies listed below) ❑ Yes ❑ No

If yes, describe _____
_____
_____

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

If yes, describe _____
_____

Does the child 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 child 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 child have hearing loss? ❑ Yes ❑ No

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

Describe the degree of hearing loss _____
_____

Does the child 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 _____

_____
_____

If yes, what is the prescription? _____

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

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

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

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

Please comment _____

Please check services currently being utilized:

❑ 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 child eat the following? (check one for each item)

	Excessive	Daily	Weekly	Rarely	Never
Vegetables					
Fruit					
Grain					
Dairy					
Fiber					
Sugar					
Artificial Sweeteners					
Artificial Colorings					
White Flour					

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

_____

_____

Describe the child'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 child takes regularly.

_____

_____

6. Behavior

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

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 teachers	❑ Yes ❑ No ❑ Not sure
Activity level	❑ Yes ❑ No ❑ Not sure	Interaction with peers	❑ Yes ❑ No ❑ Not sure
Anxiety	❑ Yes ❑ No ❑ Not sure	Affection/physical contact	❑ Yes ❑ No ❑ Not sure
Impulsivity	❑ Yes ❑ No ❑ Not sure	Sensitivity to sound	❑ Yes ❑ No ❑ Not sure
Self stimulation	❑ Yes ❑ No ❑ Not sure	Sensitivity to touch	❑ Yes ❑ No ❑ Not sure
Rigidity	❑ Yes ❑ No ❑ Not sure	Sensitivity to odors	❑ Yes ❑ No ❑ Not sure
Temper	❑ Yes ❑ No ❑ Not sure	Tics	❑ Yes ❑ No ❑ Not sure
Thumb sucking	❑ Yes ❑ No ❑ Not sure	Phobias	❑ Yes ❑ No ❑ Not sure
Friendships	❑ Yes ❑ No ❑ Not sure	Emotional reactivity	❑ Yes ❑ No ❑ Not sure
Social maturity	❑ Yes ❑ No ❑ Not sure	Pain tolerance	❑ Yes ❑ No ❑ Not sure
Perseveration	❑ Yes ❑ No ❑ Not sure	Compliance	❑ Yes ❑ No ❑ Not sure
Frustration tolerance	❑ Yes ❑ No ❑ Not sure	Cooperation	❑ Yes ❑ No ❑ Not sure
Mood	❑ Yes ❑ No ❑ Not sure	Obedience	❑ Yes ❑ No ❑ Not sure
Destructiveness	❑ Yes ❑ No ❑ Not sure	Organization	❑ Yes ❑ No ❑ Not sure
Agressiveness	❑ Yes ❑ No ❑ Not sure	Independence	❑ Yes ❑ No ❑ Not sure
Avoidance behavior	❑ Yes ❑ No ❑ Not sure	Forgetfulness	❑ Yes ❑ No ❑ Not sure
Following directions	❑ Yes ❑ No ❑ Not sure	Left/right awareness	❑ Yes ❑ No ❑ Not sure
On task	❑ Yes ❑ No ❑ Not sure	Spatial awareness	❑ Yes ❑ No ❑ Not sure
Handling change	❑ Yes ❑ No ❑ Not sure	Sense of time	❑ Yes ❑ No ❑ Not sure
Handling transition	❑ Yes ❑ No ❑ Not sure		

Comments? _____

_____

How would you describe the child'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	❑ Walking	❑ Balance
❑ High muscle tone	❑ Running	❑ Gross motor
❑ Coordination	❑ Athetoid Movement	❑ Fine motor
❑ Crawling *(on stomach)*	❑ Ataxic	❑ Stamina
❑ Creeping *(on hands and knees)*	❑ Weak	

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

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	Written language comprehension	❑ Yes ❑ No ❑ Not Sure
Receptive language	❑ Yes ❑ No ❑ Not Sure		
Letter recognition	❑ Yes ❑ No ❑ Not Sure		

Describe the child'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 (from black board)	❑ 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

Present educational placement:

Days per week _____

❑ Private ❑ Charter

❑ Behavioral ❑ Public

Hours of attendance _____

❑ Special *(Please indicate classification)*

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

_____
_____

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

_____
_____

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

_____
_____

List any exceptional abilities including academic, physical, artistic, musical, etc.

_____
_____

List any classes/lessons the client is enrolled in (Musical, Physical/Sports, Art, Languages, etc.).

_____
_____

14. Current Lifestyle

Describe the child's current activity level

❑ Unusually low ❑ Normal ❑ Unusually high ❑ Inadequately regulated

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

Types and duration of activities _____
_____

What is the child's current sleep pattern?

Sleeps from _____ to _____ Naps from _____ to _____

How much time does the child spend doing the following activities on an average day?
Homework _____
Talking on the phone _____

Playing outside _____

Video/computer games _____

Computer _____

Socializing with peers _____

Television _____

Relaxing _____

Reading _____

Listening to music _____

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

_____

Does the child play any instruments? ❑ Yes ❑ No

If yes, what? _____

Does the child play alone or does he/she enjoy company while playing?

_____
_____

What activities does the child enjoy most?

_____
_____

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

_____
_____

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

_____

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

_____

Are there any activities that the child refuses to do?

_____
_____

What are the child'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.

Signature _____ Date _____

Signature _____ Date _____