LISTENING, LEARNING DEVELOPMENT CENTRE

INITIAL CONSULTATION INTAKE FORM

CHILD'S INFORMATION

Today's Date: ....

Name ....

Age .... DOB ..... / ..... / ..... Gender .... Grade in School ....

School's Name: ....

Child's First Languange .... Primary Language at home ....

Initial Assessment Date .... By ....

Diagnostic ....

PARENT / CAREGIVER INFORMATION

Parents / Caregivers and Relationship to Child

Contact Information 1st Person

Full Name: .... E-mail: ....

Address .... City .... Province/Zip ....

Phone Home .... Work .... Cell .... Fax ....

Contact Information 2nd Person

Full Name: .... E-mail: ....

Address .... City .... Province/Zip ....

Phone Home .... Work .... Cell .... Fax ....

INTEREST IN THE PROGRAM / REFERAL INFORMATION

Please tell us about areas of concerns about for your child and the main reason for coming here today.

Please describe your interest in the Tomatis program offered at the Listening Learning and Development Centre.

Academically ....

Optimizationally ....

Developmentally ....

Socially ....

Referred by .... Phone ....

Address: ....

May we send a thank you note to your referral source? Yes .... No ....

(The Listening, Learning & Development Centre has my permission to send a thank you note to my referral source indicating my child has been seen for the initial consultation. No other information will be released without written consent.)

Parent or Guardian ....

Date ....

FAMILY HISTORY

Parents' Status (circle one): married single separated divorced deceased others

Do both parents live at home? Y/N .... If Yes Who? ....

Is there a stepmother/ stepfather? (Circle one if applicable) ....

Parents' Profession: **Mother** .... **Father** ....

Siblings

Name	Age	N = Natural A = Adopted S = Step	Gender F / M	Lives at home Y / N	Education / Ocupation	Educational / Health Issues

Other Caregivers: (daycare providers, regular babysitters, nanny, family, etc)

....

What history is there in the family regarding developmental, learning and communication disorders?
These may include: Autism, Attention, Deficit Disorder, Dyslexia, etc.

....

CHILD'S DEVELOPMENTAL/ HEALTH HISTORY

(if adopted please complete as much as possible including the "Adoption" section)

Prenatal

Was the pregnancy planed? .... Was hormone therapy used for conception? ....

Did the mother experience any health difficulties during the pregnancy? ....

Was there any other medical diagnostic and treatment during the pregnancy? (if yes, please explain)

....

Was the mother exposed to medication, smoking, alcohol, or to persistent loud sounds
(e.g., plane engines, equipment)? (if yes please comment)

....

....

Did the mother live and work in a different country during the pregnancy? Language(s) spoken at that time

....

....

Labor and Delivery

Labor length .... APGAR .... Birth Weigh ....

Was the delivery at full term? ....

Was the delivery induced? .... Was the delivery a Caesarian Section? ....

Where there any complications during the delivery process? (e.g., Hypoxia, Clavicle Fracture, Breech Delivery, etc.)

....

Adoption

Child's age when adopted .... Country of adoption ....

Please comment on the adoption process and if you have any information about birth parents

....

How do you feel the child has adjusted to his/her new home?

....

Is the child aware of adoption?

....

Infancy

Did the child have a good sleep/awake rhythm? Was the baby active or quite? Was the baby fussy or happy? Was the baby colicky for along time? (Please describe)

....

What helped the most to calm your baby when he/she was fussy or cried?

....

Was the baby breast-fed? Y/N .... Until what age? ....

Was it easy or difficult for the baby to breast-fed? ....

Did the child prefer to spend most of the time on: the belly, on the back? (Please circle)

Did the child have any long term medication or hospitalization/ surgeries during infancy? Was there any medical condition diagnosed at that time? (Please describe)

....

....

Was the baby separated from the mother for an extended period of time?

....

....

....

CHILDHOOD - Developmental Milestones (sensory - motor / speech / vision)

▶ Motor

Did your child:
Role sideways? Y/N.......... At what age (months.)?............. Sat alone? Y/N .... At what age (m.)? ....

Creep (Stomach on floor)? Y/N .... At what age (m.)? .... Crawl (Stomach off floor)? Y/N ....

At what age? .... Describe crawling style and quality ....

....

Walk without holding? Y/N .... At what age? (m) ....

For how long did the child crawl before walking? (m) ....

After beginning walking did the child fall: often, seldom, not at all ? (Please circle)

▶ Speech

When did the child first:
Babble? ....(mths.) Said first words? ....(mths.) Use 2-3 word phrases ....(mths.)

Did other people understand the child's speech? Y/N ....

Was it necessary to have a speech and language evaluation? Y/N .... At what age? ....(m).

Did the child have his/her hearing tested? Y/N .... At what age? ....(m).

Test results from the audiologist ....

Did the child have repetitive ear infection? Y/N .... How often? (during the first 5 years of life) ....

▶ Vision

Has the child had an eye exam? Y/N .... Date of child's last exam and findings ....

Has your child's ability to do any activity been restricted because of vision problems? Y/N ....
(Please describe)

....

Has the child ever worn glasses? Y/N .... If yes for distance only Y/N .... For near only Y/N ....

Does the child wear contact lenses ? Y/N .... Does the child wear glasses now? Y/N ....

Does the child wear them full time? Y/N .... Any problems? ....

Health

How would you describe the child's health during the child's first two years of life? ....

....

How would you describe the child's health since age two? ....

....

When and what was the child's most recent check-up? ....

....

Physician: ....

Is your child in good general health at the present time? ....

Are you aware of any ear, sinus, and respiratory tract infections at the present time? Y/N ....

Is the child currently taking any medication? Y/N .... Specify medication, dosage, and for what condition?

Physician: ....

Has medication been prescribed in the past to help behavior, attention and mood? Y/N ....

If yes what and dosage? ....

Did the medication help? ....

Check any conditions that apply to your child or that run in your family:

	Child	Family	Comments
Allergies			
Autism/PDD/Asperger's			
Dermatological Problems			
Diabetes			
Drug Sensitivity			
Ear, Sinus Infections			
Encopresis			
Enuresis (bedwetting)			
Environmental Sensitivities			
Genetic Syndromes			

	Child	Family	Comments
G I Tract Problems			
Head Aches			
Heart Problems			
Injuries/ Head Trauma			
Multi-System Sensory Disorders			
Respiratory Disease			
Seizure Disorder			
Sleeping Disorder			
Surgical Interventions			
Thyroid Problems			

Previous Evaluation and Treatment

Has your child been evaluated and treated by a physical or occupational therapist? Y/N ....

Findings: ....

Dates of treatment: From .... Until ....

Has your child been evaluated and treated by a speech and language pathologist or audiologist for speech and auditory problems? Y/N ....

Findings: ....

Dates of treatment: From .... Until ....

Has your child been evaluated and treated by a psychologist or learning consultant? Y/N

Findings: ....

Dates of treatment: From .... Until ....

Has your child been evaluated and treated by an ENT ? Y/N

Findings: ....

Has your child been evaluated and treated by a developmental pediatrician, neurologist or psychiatrist?

Y/N .... If Yes please specify ....

Findings: ....

Has your child been evaluated and treated by an osteopathic or naturopathic physician? Y/N

If Yes please specify ....

Findings and treatment: ....

Sensory-Motor Development

► **Laterality development:**

Hand Dominance established? Y/N .... If yes: R .... L ....

Foot Dominance established? Y/N .... If yes: R .... L ....

► **Muscle Tone Regulation -** Does the child:

Have a very sloppy/ poor posture? Y/N .... Have a too loose or too strong grasp of a pencil which is less mature than peers? Y/N ....

Drool when at rest? Y/N .... Drools when manipulating objects or when in action? Y/N ....

Have any neuromuscular pathology : (e.g. CP, spasticity, myopathy)? Y/N ....

► **Coordination, Body Scheme Awareness -** Does the child:

Appear clumsy, bumps into others? Y/N .... Have difficulties playing on playground structures? Y/N ....

Have difficulties manipulating with small objects? Y/N .... Have difficulties dressing himself/herself and fastening clothes? Y/N ....

Have difficulties eating independently while using silverware? Y/N .... Have difficulties riding a tricycle/bicycle? Y/N ....

► **Tactile Perception** - Does the child:

Dislike to being touched/cuddled? Y/N .... Object to the feel of certain clothes' texture? Y/N ....

Object to having fingernails clipped, and hair cut, teeth brushed? Y/N ....

Dislike to having face/hair washed or head under the water? Y/N .... Prefer to avoid other children's presence? Y/N ....

Vestibular Perception - Does your child:

Feel the need to swing or spin/ self spin very often? Y/N ....

Appear very hesitant when walking stairs and experiencing height? Y/N ....

Appear very cautious when in a larger and very active group of children? Y/N ....

Choose to play the less active role in different sport activities? Y/N ....

For evaluations, may I contact your child's teacher(s) at school for further information

as it relates to this assessment? Y/N ....

Contact (please include phone numbers): ....

....

Please check which areas below are most important to you to change

Attention .... Behavior ....

Eating patterns .... Emotional ....

Development .... Flexibility & transitioning ....

Focusing .... Following Directions ....

Learning .... Language ....

Math understanding ....

Memory ....

Motor skills (describe) ....

Organizational skills ....

Reading & spelling ....

Sensitivities (auditory, vestibular, visual, tactile) ....

Speech (describe) ....

....

....

Social .... Skills ....

Self-Esteem .... Sleeping ....

Patterns ....

Please check from the list below, which areas you are ready to improve?

Attention .... Academic Learning ....

Behavior .... Critical thinking ....

Emotional development .... Listening ....

Math understanding .... Memory ....

Motor skills .... Organizational skills ....

Reading & Spelling .... Social Skills ....

Speaking

Questionnaire completed by Date:

Please tell us what your desired goals are for the treatment.
Please include time-frames and specific physical/spatial/emotional improvements

....

....

....

....

....

Parent signature .... Date: ....