

Dawn Holman, PhD  
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**Client Evaluation Form**

**BACKGROUND INFORMATION AND HISTORY**

Child's Name:

\_\_\_\_\_ last first middle initial

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Boy \_\_\_\_\_ Girl \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Business #: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Business #: \_\_\_\_\_

Address: \_\_\_\_\_  
number street Apt.

\_\_\_\_\_ city state zip code

Home Telephone: ( ) - \_\_\_\_\_

Fax: ( ) - \_\_\_\_\_

Mobile: ( ) - \_\_\_\_\_

Siblings: how many? \_\_\_\_\_

1.(name)\_\_\_\_\_ (sex)\_\_\_\_\_ (age)\_\_\_\_\_ (dx)\_\_\_\_\_

2. (name)\_\_\_\_\_ (sex)\_\_\_\_\_ (age)\_\_\_\_\_ (dx)\_\_\_\_\_

3. (name)\_\_\_\_\_ (sex)\_\_\_\_\_ (age)\_\_\_\_\_ (dx)\_\_\_\_\_

4. (name)\_\_\_\_\_ (sex)\_\_\_\_\_ (age)\_\_\_\_\_ (dx)\_\_\_\_\_

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**DIAGNOSIS:**

(dx) \_\_\_\_\_ (DSM code) \_\_\_\_\_

Diagnosed By: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ age at Diagnosis: \_\_\_\_\_

**CURRENT CLINICIANS:**

Pediatrician: \_\_\_\_\_

Immunologist: \_\_\_\_\_

Allergist: \_\_\_\_\_

Neurologist:  
\_\_\_\_\_

Psychologist/Psychiatrist: \_\_\_\_\_

Speech Pathologist: \_\_\_\_\_

Occupational Therapist: \_\_\_\_\_

Other: \_\_\_\_\_

**DIAGNOSTIC TESTING:**

List date, who conducted test, and results.

Blood Tests:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Audiogram:

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Auditory Brain Stem:

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MRI / Other Brain Scans:

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Genetic Testing:

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Psychological (including any IQ testing):

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Immunological / Allergy:

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**PREVIOUS AND CURRENT TREATMENTS:** (Speech, Occupational Therapy, Behavioral Therapy, Other DIS services)

**Treatment 1:**

Type of Treatment: \_\_\_\_\_

Treatment Provider: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Child's age: \_\_\_\_\_



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Please list all current medications (including homeopathic remedies).

1. \_\_\_\_\_  
 medication for treatment of start date

\_\_\_\_\_ prescribed by

2. \_\_\_\_\_  
 medication for treatment of start date

\_\_\_\_\_ prescribed by

3. \_\_\_\_\_  
 medication for treatment of start date

\_\_\_\_\_ prescribed by

4. \_\_\_\_\_  
 medication for treatment of start date

\_\_\_\_\_ prescribed by

**DEVELOPMENTAL HISTORY:**

Describe pregnancy and delivery:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any childhood illnesses; list the child's age, the illness, and the treatment prescribed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Number of ear infections: \_\_\_\_\_

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How were these treated? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you ever suspect a hearing difficulty? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is your child hypersensitive to sound? \_\_\_\_\_ Yes \_\_\_\_\_ No

What sounds bother your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the onset of these developmental milestones:

1. Crawling \_\_\_\_\_
2. Sitting \_\_\_\_\_
3. Walking \_\_\_\_\_
4. Sleeping through the night \_\_\_\_\_
5. Eating solid foods \_\_\_\_\_
6. drinking cows milk \_\_\_\_\_
7. Speech \_\_\_\_\_

How does your child eat and sleep now?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**SELF HELP SKILLS**

Please list your child's current level of functioning on the following skills:

Toileting:

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Feeding:

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Dressing:

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Grooming:

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**BEHAVIOR:**

Non Compliance: \_\_\_\_\_ Yes \_\_\_\_\_ No

Frequency:

\_\_\_\_\_

Antecedents:

\_\_\_\_\_

Consequences used:

\_\_\_\_\_

Tantrums: \_\_\_\_\_ Yes \_\_\_\_\_ No

Frequency:

\_\_\_\_\_

Antecedents:

\_\_\_\_\_

Consequences used:

\_\_\_\_\_

Aggression: \_\_\_\_\_ Yes \_\_\_\_\_ No

Frequency:

\_\_\_\_\_

Antecedents:

\_\_\_\_\_

Consequences used:

\_\_\_\_\_

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Running Away: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Frequency:

\_\_\_\_\_

Antecedents:

\_\_\_\_\_

Consequences used:

\_\_\_\_\_

Other Behavior: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Frequency:

\_\_\_\_\_

Antecedents:

\_\_\_\_\_

Consequences used:

\_\_\_\_\_

**SELF STIMULATORY BEHAVIORS:**

Repetitive mannerisms: (hand flapping, flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Unusual attachment to objects:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Repeating previously heard words out of context - echolalia:

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Difficulty with transitions or changes in routine:

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Unusual interest in the sight, feel, sound, or smell of things:

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Unusual preoccupations / obsessions: (anything he or she likes to do repeatedly)

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Verbalizing in a repetitive manner: (ie. "eee" sounds, babbling, screaming, etc.)

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**SOCIAL BEHAVIOR:**

Does your child show you affection and how?

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Does your child play with other children? If so, describe how.

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Does your child play with toys? Appropriate or inappropriate.

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Please list your child's favorite toys, activities, music, food, games etc.

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Does your child have good eye contact? How and with whom?

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Does your child respond to his or her name? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child come to you for comfort? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child respond better to any particular person? \_\_\_\_\_ Yes \_\_\_\_\_ No

To whom? \_\_\_\_\_

Does your child greet you in anyway when he or she sees you? \_\_\_\_\_ Yes \_\_\_\_\_ No

How? \_\_\_\_\_

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Does your child show interest in other people? \_\_\_\_\_ Yes \_\_\_\_\_ No

How? \_\_\_\_\_

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Does your child attempt to involve you in something he or she is doing or get involved in something you or your family is doing? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please describe some examples:

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**LANGUAGE:**

Did your child have speech that he or she lost? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, at what age did he or she start to lose speech? \_\_\_\_\_

Was he or she ill at the time of the loss? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is your child's usual way of communicating? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Does your child cry to let you know he or she wants something? \_\_\_\_\_ Yes  
\_\_\_\_\_ No
2. Does your take you or point to what he or she wants? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Does your child say what he or she wants? \_\_\_\_\_ Yes \_\_\_\_\_ No

**RECEPTIVE:**

Does your child follow verbal directions without given any visual cues? \_\_\_\_\_ Yes  
\_\_\_\_\_ No

How much do you think your child understands?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EXPRESSIVE LANGUAGE:**

Does your child have any words? If yes, give examples.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are the words the child has used in context or out of context?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Does your child babble or combine sounds so that the combined sounds resemble some speech?

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Are there any words that your child imitates? If so, please list on the lines below.

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What is the average length of your child's utterances?

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Are there problems with your child's articulation or intonation of speech?

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Can your child hold a conversation about a favorite topic for any length of time?

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**EDUCATIONAL BACKGROUND:**

Does your child attend school? \_\_\_\_\_ Yes \_\_\_\_\_ No

What type of classroom does your child attend? Is this a DTT program?

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How long has your child been attending school?

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Does your child have an aide or shadow while attending school?

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**OTHER CURRENT SERVICES:**

Is your child receiving other DIS services at this time? (behavior modification, speech, OT)

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**GOALS AND OBJECTIVES:**

Please list some goals that you would like your son or daughter to achieve by doing behavior modification therapy services. (ie. eating different kinds of foods or speaking in sentences, etc.)

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**Pre-academics & Academics:**

Coloring:

Drawing:

Writing:

Reading:

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**Social:**

Toys

Games

Sports

Speech and Language:

Tone

Intonation

Articulation