Application For Testing and/or Educational Therapy Program

Name of Student _____ Date _____

Birthdate _____ Age _____ Grade _____ Sex ____ School___ _____

Father _____ Occupation _____ Work Phone _____

Email _____ Cell Phone _____

Mother _____ Occupation _____ Work Phone _____

Email _____ Cell Phone _____

Home Phone _____ Circle which phone can receive text messages.

Home Address _____City _____ State ____ Zip _____

Family History

Child is living with (check all that apply)

___ birth father ___ step father ___ birth mother ___ stepmother

___ grandparent ___foster care ___ legal guardian ___ adoptive parents

Since the child's birth there has been: **Reaction of the child:**

___ death in family _____

___ separation _____

___ divorce _____

___ remarriage of mother _____

___ remarriage of father _____

___ other major trauma _____

Other Children in the family

Name	Gender	Age	Grade	Present School
_____	____	____	____	_____
_____	____	____	____	_____
_____	____	____	____	_____

Is there a history of learning difficulties in your family? ___ yes ___ no

If yes, please explain _____

_____

Briefly describe your child's relationship with you, your spouse, and other members of the family:

_____

_____

Name of the place of worship your family attends _____

Medical/ Developmental History

Child was ___ full term ___ premature

State any complications during pregnancy with mother or child: (toxemia, diabetes, illness, drugs, abuse …)

_____

State any complications your child had immediately after birth (breathing, bluish color, other…)

_____

Check where applicable:

___ recent physical exam year/results _____

___ recent vision exam year/results _____

___ recent hearing exam year/results _____

___ recent speech evaluation year/results _____

Check any problems in infancy or childhood with:

___ colic ___ talking ___ crawling ___ walking/running ___ sleeping ___ bedwetting

___ eating ___ general slow to develop ___ behaviors (explain _____)

Child: (check where applicable)

___ needs glasses ___ wears glasses ___ has/had frequent ear infections ___has allergies/asthma

___ has/had high fevers ___ has/had hearing problems ___has/had seizure, convulsions, or staring spells

___ had injury/accident to head ___ needs/wears hearing device

Explain any items checked: _____

Educational History

List all schools previously attended (Preschools to present)

School Grades Reason for change

_____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Child writes with: ___ right hand ___ left hand ___ uses both hands ___mirror writer

Child (check where applicable):

___ repeated grade(s): Which grades? _____because _____

___ received tutoring: which grade & subjects? _____

___ enrolled in special class: what kind? _____

___ has been fully evaluated ____ WISC (cognitive) ____ Achievement ___Visual- motor ___ other

___ has a special education plan ___ IEP ___ IFSP ___ 504 Plan ___ Speech ___ OT ___ PT ___ ABA

___ has/had speech & language therapy: When (years) _____ for what? _____

___ has/had occupational therapy: When (years) _____

___ has/had vision therapy: When (years) _____ for what? _____

Child has been diagnosed as having: ___ ADD ___ ADHD ___ a Specific Learning Disability ___ other

Explain specifics _____

State child's best and worst subject: Best- _____, Worst- _____

Additional Comments about schooling: _____

State the area(s) in which you feel your child needs help:

_____

_____

_____

_____

Social/Behavioral History

Circle where applicable in describing your child below:

Independent	Lacks common sense	Stubborn	Dependent
Anxious	Easily distracted	Aggressive	Complains about school
Dishonest	Overly fearful	Withdrawn	Overly sensitive
Shy	Enjoys school	Moody	Self-centered
Passive	Makes friends easily	Confident	Easily frustrated
Prefers playing with much older children	Prefers playing with much younger children	Athletic	Not athletic

Is there any additional information you would like to personally share with the educational therapist? __ yes ___ no

Permission to Test

We give our permission for (name of evaluator/therapist) _____

to test our child, _____. The fee for testing is $495.00 for the school year 2018-19. This fee includes a follow-up meeting to discuss the results, along with a written report. The testing fee balance is due at that time. A psychologist will be giving the cognitive test, and is allowed to share results with the therapist. The evaluator has our permission to share the test results with the psychologist.

The testing registration fee of $60.00 is due with this application and is not refundable.

By signing below, we agree that the information give on this form is accurate and true.

Father: _____ Date _____

Mother: _____ Date _____

Or

Guardian: _____ Date _____

Or

Self (if over 18 years old) _____ Date _____

Vicki A. Nolt, M.Ed.

Educational Therapist, PCET, CDT

vickinolt@gmail.com

540-578-0161