

Little Giant Steps

Jan Bedell

Certified Neurodevelopmentalist

P.O. Box 863624 Phone (972) 758-1260

Plano, TX 75086 Fax (972) 325-4119

Website: www.littlegiantsteps.com Email: support@littlegiantsteps.com

____ Send in 4 weeks
____ Bring to next eval

EVALUATION REPORT FORM

**Please fill out one of these forms and send with your weekly data sheet for your first month.
Thereafter, you will bring one each time you have an appointment with your evaluator.**

Client's Name: _____ Age: _____ Today's Date: _____

Parent's Names: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

E-mail: _____

1. List any medications or dietary supplements, which the client is receiving:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

2. Indicate any specific diet, or dietary limitations.

3. List any specific health problems that have occurred since last evaluation: (Seizures, infections, operations, etc.)

4. Indicate schools/classes being attended, extra curricular activities, therapies and employment status.

5. What percentage of the total plan has been accomplished since the last evaluation? _____

6. Indicate any activities that you have not been able to accomplish and why.

7. Please make specific comments in each of the following relative areas; include successes, changes, concern, difficulties, and/or other observations.

A. Tactility: (Sensitivity to touch, temperature, odors, tastes, shoes; bedwetting problems, etc.)

B. Auditory Function: (Following directions, memory, attention span, hyper-sensitivity to sound, etc.)

Indicate Level at Testing: Digit Span____, Digit Span with Letters____, ACWS____, Object Sequences____

Indicate Current Level: Digit Span____, Digit Span with Letters____, ACWS____, Object Sequences____

Samonas Sound Therapy:

CD: _____ Times per Day: _____ How many minutes: _____
CD: _____ Times per Day: _____ How many minutes: _____
CD: _____ Times per Day: _____ How many minutes: _____

C. Visual Function: (Letter and/or number reversals, eye convergence and tracking, eye contact etc.)

Indicate Level at Testing: Digit Span _____, VFD____, Object Sequences _____

Indicate Current Level: Digit Span _____, VFD____, Object Sequences _____

D: Manual/ Fine Motor Function: (Opening jars, printing or cursive writing, pencil grasp, etc.)

E. Language: (Articulation, pronunciation, conversational skills, stuttering, mouth breathing, etc.)

F. Mobility/ Gross Motor Function: (Crawling, walking, coordination, balance, endurance, etc.)

G. Academic Function: "What Your ___ Grader Needs To Know" page _____
Math Book _____ page _____
NPR _____ page _____
Science _____ page _____
Cursive _____ page _____
Other _____ page _____

H. Behavior: (Emotionality, cooperation, rigidity, mood swings, depression, attitude, obedience, etc.)

J. Social: (Interaction with others, appropriate play, etc.)

