

How did you learn about Little Giant Steps? (please be specific) _____

Have you attended a Neurodevelopmental seminar? _____

Have you either listened to tapes/CD or watched a DVD on the Neurodevelopmental Approach? _____

HISTORY (Birth to Present)

Client's Name _____ Date _____

Client's birth weight _____ lbs. _____ oz. Length of pregnancy _____

Complications during pregnancy and/or delivery? yes/no If yes, please describe: _____

Has client ever received a head injury? yes/no If yes, please describe, including age: _____

Ear infections/respiratory/sinus problems? yes/no If yes, list age(s) and corresponding problem(s):

Broken limbs? yes/no If yes, identify which limb(s) and age(s) of injury: _____

Any concerns with any organs? yes/no _____

Headaches? yes/no _____

Surgeries? yes/no If yes, identify with corresponding age(s): _____

Seizures? yes/no If yes, please list ages and describe in detail: _____

Medications? Please list past and current, including age, dosage, and purpose for each: _____

Supplements? yes/no If yes, please list current only: _____

Client's Name _____ Date _____

Allergies? yes/no If yes, please identify, including ages and whether food, chemical, etc: _____

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

- | | | | |
|---------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> near sighted | <input type="checkbox"/> far sighted | <input type="checkbox"/> astigmatism | <input type="checkbox"/> amblyopia |
| <input type="checkbox"/> strabismus | <input type="checkbox"/> macular problems | <input type="checkbox"/> glaucoma | <input type="checkbox"/> cataracts |
| <input type="checkbox"/> nystagmus | <input type="checkbox"/> color blindness | <input type="checkbox"/> cortical blindness | <input type="checkbox"/> blind |

Has the client had a recent eye examination? Yes/no Date _____

Does the client wear glasses or contact lenses? yes/no If yes, give prescription: _____

Has the client ever received vision therapy? yes/no If yes, give details: _____

AUDITORY: Please identify any testing done and diagnoses received. Indicate dates and summarize results. Please attach copies when available.

Hearing loss? yes/no If yes, indicate age loss occurred, which ears effected, decibel range, cad cause, etc: _____

Tinnitus? yes/no If yes, indicate age occurred, which ears effected, family history of tinnitus: _____

Hyperacute hearing? yes/no If yes, indicate age occurred and severity of symptoms: _____

Has client had an audiogram, tympanogram, or ABR done? yes/no EXPLAIN: _____

Has client received any Tomatis, AIT, AET, SHS, Listening Program, and/or Samonas auditory training? yes/no If yes, indicate the forms of auditory training with the dates and results: _____

Has client had any medical testing done (MRI, CAT, Blood, Thyroid, etc.)? yes/no _____

Has client had any nutritional testing done (Blood analysis, hair analysis, urine analysis, etc.)? yes/no _____

Client's Name _____ Date _____

DIETARY: Please submit a 7-day food diary. A handout is attached at the end of this document for your convenience.

Was the client nursed? _____ Weaned at age _____ Solid food started at age _____

Describe the client's current diet _____

Describe any past/current dietary or eating concerns:

poor appetite _____ food cravings _____

picky eater _____ anorexia/bulimia _____

over eating _____

	Excessive	Daily	Weekly	Rarely	Never
sugar	_____	_____	_____	_____	_____
fruits	_____	_____	_____	_____	_____
meats	_____	_____	_____	_____	_____
vegetables	_____	_____	_____	_____	_____
artificial sweeteners	_____	_____	_____	_____	_____
caffeine/soft drinks	_____	_____	_____	_____	_____
carbohydrates	_____	_____	_____	_____	_____
artificial colorings	_____	_____	_____	_____	_____
dairy products	_____	_____	_____	_____	_____
white flour	_____	_____	_____	_____	_____
tobacco	_____	_____	_____	_____	_____
alcohol	_____	_____	_____	_____	_____

DEVELOPMENTAL: Please indicate the age in months and years these developmental steps were achieved:

crawled (on stomach) _____ years _____ months

crept (on hands and knees) _____ years _____ months

walked _____ years _____ months

toilet trained _____ years _____ months

first word _____ years _____ months

use of couplets (two words together) _____ years _____ months

3-4 word phrases _____ years _____ months

sentences _____ years _____ months

conversational language _____ years _____ months

initial word recognition/reading _____ years _____ months

Please indicate if the client enjoys the following activities and the amount of time spent on each per day:

television watching _____

being read to _____

looking at books _____

reading books _____

sports/exercise activities (indicate activity) _____

Please indicate if there are any concerns in the following areas:

muscle tone (low or high) _____

coordination _____

balance _____

Client's Name _____ Date _____

- crawling _____
- walking _____
- running _____
- weakness _____
- bedwetting _____
- articulation problems _____
- stammer/stutter _____
- language ability _____
- poor pencil grasp _____
- sloppy writing _____
- letter reversals _____
- mirror writing _____
- left/right confusion _____
- sleep times _____
- physical activity level _____

HAND PREFERENCE: Please indicate whether right, left, or mixed.

- writing _____ drawing/coloring _____
- eating _____ brushing/combing hair _____
- throwing _____ brushing teeth _____

Have you ever felt that this person should really be the opposite hand? _____ Did they take a long time to choose hand dominance? _____ Were they encouraged one way or the other? _____

ACADEMICS: Please indicate if there are any concerns in the following areas:

- reading _____
- reading comprehension _____
- math computation _____
- math concepts _____
- math word problems _____
- logical thinking _____
- poor at testing _____

BEHAVIOR: Please indicate which items apply on a scale of 0 to 5 (with 0 indicating no concern and 5 indicating highest level of concern):

- | | |
|--|--|
| distractibility _____ | competitive _____ |
| short attention span _____ | avoidance behavior _____ |
| hyperactive _____ | difficulty following directions _____ |
| hypoactive (low activity level) _____ | difficulty with parents _____ |
| rigid or inflexible _____ | difficulty with siblings _____ |
| impulsive _____ | difficulty with teachers _____ |
| explosive temper _____ | difficulty with peers _____ |
| sucks thumb _____ | overly sensitive to sound _____ |
| few or no friends _____ | overly sensitive to pain _____ |
| socially immature _____ | overly sensitive to odors _____ |
| bites nails _____ | overly sensitive to taste/textures _____ |
| perseveration (endless repetition) _____ | tics _____ |
| anger (non explosive) _____ | phobias _____ |
| low frustration level _____ | emotional _____ |
| overreacts _____ | overly sensitive _____ |
| destructive behavior _____ | social _____ |

Client's Name _____ Date _____

List all schools/programs attended (please include dates, grades, and degrees). If home schooled, please list curriculum: _____

List any labels or classifications: _____

List any extra curricular activities, sports or lessons: _____

GOALS AND PLAN

List goals and expectations: _____

List daily amount of time available to work with client and who will be working with client: _____

Little Giant Steps and Little Giant Steps Neurodevelopmentalist are a Christian educational organization. Little Giant Steps (LGS) utilizes an eclectic approach to eliminating learning, motor and speech inefficiencies. The developmental and educational plans are individualized for each client. Activities recommended are not medical, therapeutic, or psychological prescriptions. Activities are offered for the client and families' review, investigation and education. Application of activities is the responsibility of the client and family. LGS Neurodevelopmentalists are educators and are not licensed to practice medicine. If medical or other licensed professional advice is needed, the family is urged to consult a licensed physician or other licensed professional.

I acknowledge that I have read and completed this information to the best of my knowledge and ability, and that I understand that Little Giant Steps or those trained by or employed by LGS are not assuming responsibility or liability for the client, and that I, as parent, guardian or client, assume full responsibility. I agree to give my full commitment to this program.

Signature _____ Date _____ Signature _____ Date _____



Little Giant Steps

neurodevelopmental innovations

New Parent Orientation and Commitment Letter

Little Giant Steps has a unique approach to addressing learning difficulties and disabilities. The techniques used on the individualized programs are tried and true, having received proven results with thousands of children across the country for more than 30 years. The successful elimination of neurological inefficiencies has only been present where the programs have been implemented with consistency over a long enough period of time. To accomplish your goals as a new parent on our program, we ask you to review this mutual commitment agreement.

My commitment to you as your evaluator:

- ✓ Perform the most comprehensive evaluations possible.
- ✓ Supply you with up-to-date activities to address the challenges your child is experiencing.
- ✓ Make support available by phone and e-mail to discuss any concerns or challenges you may be experiencing in implementing the program.

Your commitment:

- ✓ Implement the program activities as described, **without additions or deletions**, unless you have received approval on a variation from your evaluator.
- ✓ Call or e-mail **immediately** with any concerns about implementing your program.
- ✓ Put program activities in a higher priority than any curriculum until the root issues plaguing your child have been addressed.

I understand that services and support are based on four month time periods, or trimesters, and each trimester begins with an evaluation.

I understand that if we are unable to attend the scheduled four-month re-evaluation, we must submit a written report (report form will be provided), along with a \$50.00 fee within four months of the previous evaluation in order to keep our status as a current client and continue receiving services and support for the next trimester.

I understand that if we do not attend an evaluation within **6 months** of our previous evaluation and we do not submit a report and fee, the cost of our next evaluation will increase by \$100.00

I understand that a deposit of \$225.00 is required at each evaluation in order to secure an appointment for the next evaluation and that deposits will be refunded **only** for appointments which are cancelled **at least five weeks prior to the scheduled appointment**.

I realize that as of the initial evaluation, I am making at least a **one year commitment** to impact my child's life in such a way that he/she will benefit for the rest of his/her life. I understand that the cause of the symptoms my child is experiencing will not change without direct intervention from myself or someone I assign to implement the program. This is not a binding financial contract, but an understanding that the changes I desire for my child require twelve to eighteen months of direct intervention with supervision to secure lasting change.

_____ **Date** _____
Parent/Guardian Signature

Evaluator Signature

