Healing Pathways Medical Clinic

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PATIENT HISTORY AND PROGRAM APPLICATION
NEURO ASSESSMENT FORM

Today's Date _____
Form is completed by Self___Spouse_____Parent_____Guardian_____ (please check one)

Patient's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
E-mail address _____

Patient lives with Self____Spouse ____ Parent_____Guardian_____Other_____(please check one)
Was the patient adopted? ___Yes _____ No

Father's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Occupation _____

Mother's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Occupation _____

Guardian's Name _____ Date of Birth _____
Address _____ Telephone Home _____
City _____ Work _____
State _____ Zip Code _____ Fax _____
Occupation _____

How did you become aware of neurodevelopment?
__NACD Family ____Professional Group (Please Specify) _____

__Publication (Please Specify)_____ Internet (Please Specify) _____

__Yellow page ad. ___News ad. __Other (Please Describe)_____

Have you attended any lectures on Brain Development by Healing Pathways Medical Clinic?
_____Yes/No Spouse_____Yes/No

Patient's Name _____ **Date** _____

MEDICAL HISTORY

Primary Family Physician _____ Telephone _____
Address _____
_____

Patient's birth weight _____lbs. ____oz
Length of pregnancy _____
Complications during pregnancy and/or delivery? Yes/No
Please describe _____
_____

Pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date	Examined by	Diagnosis	Recommendations

Surgeries? Yes/No
Please describe_____
_____

Seizures? Yes/No
Frequency of Seizures _____ Length _____
Type(s) _____
_____

Currently taking seizure medication? Yes/No
List medication(s) _____
Seizure medications taken previously? Yes/No
List medication(s) _____
Currently taking other medications? Yes/No
List medication(s) _____
Are there any medical problems that place limitations on physical activity, etc.? Yes/No
List _____
_____
Broken limbs? Yes/No
List specifics _____
_____

Patient's Name _____ **Date** _____

HEALTH

Describe the patient's diet _____

_____

_____

	Excessive	Daily	Weekly	Rarely	Never
Vegetables					
Fruits					
Meats					
Sugar					
Artificial Sweeteners					
Artificial Colorings					
Dairy Products					
White Flour					
Tobacco					
Alcohol					

List dietary supplements and vitamins

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Food allergies? Yes/No/Never tested

_____ _____ _____

_____ _____ _____

_____ _____ _____

Food craving? Yes/No

Picky eater? Yes/No

Overeats? Yes/No

Poor appetite? Yes/No

Allergies? Yes/No

If yes, please describe _____

Does the patient have a history of colds or sinus congestion? Yes / No

Does the patient have a history of ear infections? Yes / No

If yes, which ears have been affected? _Left _Right _Both

Does patient have Tinnitus? Yes / No

If yes, which ears have been affected? _Left _Right _Both

Is Tinnitus _continuous _intermittent

Does the patient have a hearing loss? Yes / No

If yes, which ears have been affected? _Left _Right _Both

Degree of hearing loss _____

Does the patient have hypersensitive hearing? Yes / No

Has the patient had a tympanogram, audiogram, ABR? Yes / No

If yes, what were the results? _____

Patient's Name _____ **Date** _____

Has the patient had an eye examination? Yes / No
Does the patient wear eyeglasses or contact lens? Yes / No
If yes, what is the prescription? _____
Has the patient been diagnosed with any of the following: (please check all that apply)

_Near sighted	_Far sighted	_Astigmatism	_Amblyopia
_Strabismus	_Macular problems	_Glaucoma	_Cataracts
_Nystagmus	_Blind	_Cortical blindness	_ Other_____

Has the patient ever received vision therapy? Yes / No
Please comment _____
_____

Patient physical activity level
Daily? Yes / No
How many days per week? _____
Types of activities _____
_____
Duration of activities _____
_____

Is the Patient seeing a specialist? (*Please check all that apply*)

_Neurologist	_Occupational therapist	Other _____
_Psychiatrist	_Physical therapist	_____
_Psychologist	_Speech therapist	_____
_Orthopedist	_Vision therapist	_____
_Cardiologist	_Music therapist	_____
_ Chiropractor	_Tutor	_____
_ Nutritionist	_Counselor	_____

Other health problems? Yes/No
List _____
_____

BEHAVIOR
Does the patient have a history of emotional or behavioral disorders? Yes/No
Please describe_____
Is there a family history of emotional or behavioral disorders? Yes/No
Please describe_____
Patient's specific positive behaviors _____
Patient's specific negative behaviors _____

Do you have specific behavioral goals for the patient? Yes/No
Please describe _____
_____
_____

Patient's Name _____ **Date** _____

BEHAVIOR

Distractibility	Yes/no/Not sure	Likes competitive games	Yes/No/Not sure
Short attention span	Yes/No/Not sure	Avoidance behavior	Yes/No/Not sure
Hyperactive	Yes/No/Not sure	Difficulty following directions	Yes/No/Not sure
Hypoactive (low activity level)	Yes/No/Not sure	Difficulty with parents	Yes/No/Not sure
Rigid or inflexible	Yes/No/Not sure	Difficulty with siblings	Yes/No/Not sure
Impulsive	Yes/No/Not sure	Difficulty with teachers	Yes/No/Not sure
Temper tantrums	Yes/No/Not sure	Difficulty with peers	Yes/No/Not sure
Sucks thumb	Yes/No/Not sure	Overly sensitive to sound	Yes/No/Not sure
Few or no friends	Yes/No/Not sure	Overly sensitive to touch	Yes/No/Not sure
Socially immature	Yes/No/Not sure	Overly sensitive to odors	Yes/No/Not sure
Perseverating		Tics	Yes/No/Not sure
(fixation on a topic)	Yes/No/Not sure	Phobias	Yes/no/Not sure
Low frustration level	Yes/No/Not sure	Emotional	Yes/No/Not sure
Overreacts	Yes/No/Not sure	Overly sensitive	Yes/No/Not sure
Destructive behavior	Yes/No/Not sure	High tolerance for pain	Yes/No/Not sure
Aggressive behavior	Yes/No/Not sure	Low tolerance for pain	Yes/No/Not sure
Cyclical behavior		Compliant	Yes/No/Not sure
(good days/bad days)	Yes/No/Not sure	Cooperative	Yes/No/Not sure
Academic output		Obedient	Yes/No/Not sure
(good days/bad days)	Yes/No/Not sure	Organized	Yes/No/Not sure
Achievement (high in some cases,		Flexible	Yes/No/Not sure
but low in others)	Yes/No/Not sure	Social	Yes/No/Not sure
Disorganized	Yes/No/Not sure	Prefers to play with children younger than their age	Yes/No/Not sure
Plays appropriately with toys	Yes/No/Not sure		

PHYSICAL MOTOR SKILLS (please check problem areas)

Low muscle tone	_____	Athetoid movement	_____
High muscle tone	_____	Ataxic movement	_____
Coordination	_____	Weak	_____
Crawling	_____	Balance	_____
Creeping	_____	Other_____	
Walking	_____	_____	
Running	_____	_____	

BEDWETTING

Does patient currently wet the bed? _____
At what age did the patient stop bedwetting? _____
Is there a family history of bedwetters? _____

SLEEP PATTERNS

Is the patient a deep sleeper? Yes/No Trouble getting to sleep? Yes/No
Well rested after sleep? Yes/No Trouble waking up? Yes/No
Sleeps from _____ to _____

Patient's Name _____ **Date** _____

HAND PREFERENCE

	Right	Mixed	Left
Writing	_____	_____	_____
Eating	_____	_____	_____
Throwing	_____	_____	_____
Brushing teeth	_____	_____	_____
Combing hair	_____	_____	_____
Other_____	_____	_____	_____
_____	_____	_____	_____

LANGUAGE AND READING SKILLS

Articulation problems	Yes/No/Not sure	Mirror writing	Yes/No/Not sure
Stammer or stutter	Yes/No/Not sure	Forgetful	Yes/No/Not sure
Aphasia (word absence)	Yes/No/Not sure	Right, left confusion	Yes/No/Not sure
Poor pencil grasp	Yes/No/Not sure	Poor judge of time	Yes/No/Not sure
Sloppy writing	Yes/No/Not sure	Poorly organized	Yes/No/Not sure
Difficulty copying from a blackboard	Yes/No/Not sure	Poor reading ability	Yes/No/Not sure
Letter reversals	Yes/No/Not sure		

MATH RELATED (circle areas of concern)

Computation	Yes/No/Not sure	Word problems	Yes/No/Not sure
Concepts	Yes/No/Not sure	Poor logic	Yes/No/Not sure

THINKING RELATED (Please circle area of concern)

Visualization	Yes/No/Not sure	Conceptualization	Yes/No/Not sure
Long Term	Yes/No/Not sure	Short Term Memory	Yes/no/Not sure

DEVELOPMENTAL HISTORY

Age	Crawled (on stomach)	_____ Years	_____ Months
	Crept (on hands and knees)	_____ Years	_____ Months
	Walk	_____ 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
	Read	_____ Years	_____ Months

Does the patient enjoy watching television?	Yes/No
Does the patient enjoy being read to?	Yes/No
Does the patient enjoy reading books?	Yes/No
Speech and language problems?	Yes/No
Fine motor problems?	Yes/No
Gross motor problems?	Yes/No

Patient's Name _____ **Date** _____

EDUCATIONAL HISTORY

List all schools/programs attended, years attended, grade completed or degrees earned.

_____
_____
_____
_____
_____
_____

List any educational problems (past or current).

_____
_____
_____

List any labels, classifications, or educational diagnoses (past or current).

_____
_____
_____

List specific skills needed to perform job. _____
_____
_____

List any exceptional abilities, academic, physical, artistic, musical, etc.

_____
_____
_____

Lessons (musical, physical/sports, art, language, etc.)

_____
_____

Are there any events which may be currently affecting the client adversely? Yes/No
Please describe_____
_____

GOALS AND PLANS

What are your goals and expectations for the patient?
Professionally:_____
_____
Academically:_____
_____
Personally:_____
_____

Patient's Name _____ **Date** _____

Who will implement the therapy programs? _____

_____

Daily length of time therapies can be implemented _____

Neuro development assessments and therapies are not medical treatments but rather address neurological organization, processing skills, and developmental deficits. Neither are they licensed or regulated by the State of Arizona. By signing below you state that you are aware of these facts and have had all pertinent questions answered.

Signature _____ Date _____

Signature _____ Date _____

We at Healing Pathways Medical Clinic are serious about you or your child's health and wellbeing. To help assure success with a therapy program we desire to become involved with your individual school district, special education classroom, therapists and other caregivers to assure full dissemination of therapy plans and goals.

"Helping hurt kids to become normal and normal kids become exceptional"