Sacarin Listening, Movement and Development Center
5901 Roosevelt Way NE #C, 1240 116th Ave NE Suite 220
Seattle, WA 98105 (206) 522-8873 www.sacarin.com Bellevue, WA 98104

Initial Consultation Comprehensive Questionnaire

CHILD'S INFORMATION **Today's Date**_____

Child's Name_____

Age____ DOB___/__/___ Sex: ___ Grade in School___ School Name_____

Child's First Language_____ Primary Language at Home_____

Initial Assessment Date___/___/__ by _____Diagnostic_____

PARENT/ PRIMARY CAREGIVER INFORMATION

Parents/ Primary Caregiver and Relationship to Child:_____ ____

Contact information:
1st Person_____ E-Mail _____

Address_____City_____State/Zip_____

Phone: Home_____Work_____Cell_____Fax_____

2nd Person _____ E-Mail_____

Address_____City_____State/Zip_____

Phone: Home_____ Work_____ Cell_____ Fax_____

INTEREST IN THE PROGRAM / REFERAL INFORMATION

This is your opportunity to tell us about areas of concerns about your child and the main reason for coming here today and describe your interest in the programs offered at the Sacarin Center

Academic_____

Optimization_____

Developmental_____

Social_____

Referred by_____Phone_____Adress_____

May we send a thank you note to your referral source? ____Yes ____No
The Sacarin Center has my permission to send a thank you note to my referral source indicating my child has been seen for the initial consultation. No other information will be released without written consent.
Parent or Guardian_____ Date_____

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FAMILY HISTORY

Parents' Status (circle one) married single separated divorced deceased others
Do both parents live at home? Y/N____ If Yes Who? _____
Is there a stepmother/ stepfather? (Circle one if applicable)
Parents' Profession: Mother_____ Father_____
Siblings

Name	Age	N=Natural A=Adopted S=Step	Sex M/F	Lives at Home Y/N	Education/ Occupation	Educational/ Health Issues

Other Caregivers: (daycare providers, regular babysitters, nanny, family, etc)_____

What history is there in the family regarding developmental, learning and communication disorders? These may include: Autism, Attention Deficit Disorder, Dyslexia, etc. _____
_____
_____

CHILD'S DEVELOPMENTAL/ HEALTH HISTORY

(if adopted please complete as much as possible including the "Adoption" section)

Prenatal

Was the pregnancy planed? _____Was hormone therapy used for conception?_____

Has the mother experienced any health difficulties during the pregnancy? Was there any other medical diagnostic and treatment during the pregnancy? (if yes, please explain)_____
_____

Was the mother exposed to medication, smoking, alcohol, or to persistent loud sounds (e.g., plane engines, equipment)? (if yes please comment)_____
_____

Did the mother live and worked in a different country during the pregnancy?
Language(s) spoken at that time _____

Labor and Delivery

Labor length _____ APGAR_____ Birth Weigh_____
Was the delivery at full term? _____
Was the delivery induced? _____
Was the delivery a Caesarian Section?
_____

Where there any complications during the delivery process? (e.g., Hypoxia, Clavicle Fracture, Breech Delivery, etc.) _____

Adoption
Child's age when adopted_____ Country of adoption_____

Please comment on the adoption process and if you have any information about birth parents_____
_____

How do you feel the child has adjusted to its new home?_____
_____

Is the child aware of adoption? _____

Postnatal/Infancy
Did the child have a good sleep/awake rhythm? Was the baby active or quite? Was the baby fussy or happy? Was the baby colicky for along time? (Please describe)_____
_____
_____
_____
What helped the most to calm your baby when it was fussy or cried? _____
_____
Was the baby breastfed? Y/N _____ Until what age?_____ Was it easy or difficult for the baby to breast fit?_____
_____
Did the child prefer to spend most of the time on: the belly, on the back? (Please circle)

Did the child have any long term medication or hospitalization/ surgeries during infancy? Was there any medical condition diagnosed at that time? (Please describe)_____
_____
_____
Was the baby separated from the mother for and extended period of time? _____
_____

Childhood

Sensory-Motor/ Speech/ Vision Developmental Milestones
Motor
Did your child:
Role sidewise? Y/N__ At what age (months.) ?____ **Sat** alone? Y/N__ At what age (m.)?____
Creep (Stomach on floor)? Y/N ____At what age (m.)?___
Crawl (Stomach off floor)? Y/N___ At what age? ____ Describe crawling style and quality_____

Walk without holding? Y/N____ At what age?_____ (m).
For how long did the child crawl before walking? ___(m).

After beginning walking did the child fall: often, seldom, not at all? (Please circle)

Speech:
When did the child first:
Babbled? _____(m.) Said first words? _____ (m).
Use 2-3 word phrases_____ (m)..
Did other people understand the child's speech? Y/N

Was it necessary to have a speech and language evaluation? Y/N __ At what age? ___(m).
Did the child have its hearing tested? Y/N_____ At what age? _____(m).
Test results from the audiologist_____
Did the child have repetitive ear infection? Y/N ___ How often? (during the first 5 years of life)____

Vision:
Has the child had an eye exam? Y/N_____ Date of child's last exam and findings____
_____
Has your child's ability to do any activity been restricted because of vision problems? Y/N____ Please describe_____
_____
Has the child ever worn glasses? Y/N_____ If yes for distance only Y/N_____ For near only Y/N_____ Does the child wear contact lenses ?Y/N_____
Does the child wear glasses now? Y/N_____ Does the child wear them full time? Y/N _____Any problems?_____

Health:

How would you describe the child's health during the child's first two years of life? ___
_____
How would you describe the child's health since age two? _____
_____
When and what was the child's most recent check-up? _____
_____Physician:_____
Is your child in good general health at the present time? _____
Are you aware of any ear, sinus, respiratory tract infection at the present time? Y/N_____
_____
Is the child currently taking any medication? Y/N_____ Specify medication, dosage, and for what condition?_____
_____Physician:_____
Has medication been prescribed in the past to help behavior, attention and mood? Y/N____ If yes what and dosage?_____
Did the medication help?_____

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Check any conditions that apply to your child or that run in your family:

	Child	Family	Comments
Allergies	_____	_____	_____
Autism/PDD/Asperger's	_____	_____	_____
Dermatological Problems	_____	_____	_____
Diabetes	_____	_____	_____
Drug Sensitivity	_____	_____	_____
Ear, Sinus Infections	_____	_____	_____
Encopresis	_____	_____	_____
Enuresis (bedwetting)	_____	_____	_____
Environmental Sensitivities	_____	_____	_____
Genetic Syndromes	_____	_____	_____
G I Tract Problems	_____	_____	_____
Head Aches	_____	_____	_____
Heart Problems	_____	_____	_____
Injuries/ Head Trauma	_____	_____	_____
Multi-System			
Sensory Disorders	_____	_____	_____
Respiratory Disease	_____	_____	_____
Seizure Disorder	_____	_____	_____
Sleeping Disorder	_____	_____	_____
Surgical Interventions	_____	_____	_____
Thyroid Problems	_____	_____	_____

Previous Evaluation and Treatment

Has your child been evaluated and treated by a physical or occupational therapist? Y/N__
Findings:_____
Dates of treatment: From _____ Until_____

Has your child been evaluated and treated by a speech and language pathologist or audiologist for speech and auditory problems? Y/N_____
Findings:_____
Dates of treatment: From _____ Until_____

Has your child been evaluated and treated by a psychologist or learning consultant? Y/N_____
Findings:_____
Dates of treatment: From _____ Until_____

Has your child been evaluated and treated by an ENT ? Y/N_____
Findings:_____

Has your child been evaluated and treated by a developmental pediatrician, neurologist or psychiatrist? Y/N_____ If Yes please specify_____
Findings:_____

Has your child been evaluated and treated by an osteopathic or naturopathic physician? Y/N_____ If Yes please specify_____
Findings and treatment:_____

Sensory-Motor Development

Laterality development:
Hand Dominance established? Y/N____ If yes: R____ L_____
Foot Dominance established? Y/N_____ If yes: R____ L_____

Muscle Tone Regulation:
Does the child:
Have a very sloppy/ poore posture? Y/N_____
Have a too loose or too strong grasp of a pencil which is less mature than peers? Y/N___
Drool when at rest? Y/N___ Drools when manipulating objects or when in action? Y/N__
Have any neuromuscular pathology:(e.g. CP, spasticity, miopathy)?Y/N _____

Coordination, Body Scheme Awareness:
Does the child:
Appears clumsy, bumps into others? Y/N____
Have difficulties playing on playground structures? Y/N____
Have difficulties manipulating with small objects? Y/N____
Have difficulties dressing himself and fastening clothes? Y/N____
Have difficulties eating independently while using silverware? Y/N____
Have difficulties riding a tricycle/bicycle? Y/N____

Tactile Perception
Does the child:
Dislike to being touched/cuddled? Y/N_____
Object to the feel of certain clothes' texture? Y/N_____
Object to having fingernails clipped, and hair cut, teeth brushed? Y/N_____
Dislike to having face/hair washed or head under the water? Y/N_____
Prefer to avoid other children's presence? Y/N_____

Vestibular Perception:
Does your child:
Feel the need to swing or spin/ self spin very often? Y/N_____
Appear very hesitant when walking stairs and experiencing height? Y/N _____
Appear very cautious when in a larger and very active group of children? Y/N_____
Choose to play the less active role in different sport activities? Y/N_____

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For evaluations, may I contact your child's teacher(s) at school for further information as it relates to this assessment?
No_____
Yes _____Please speak to (include phone numbers)

_____
_____
_____

Parent Signature_____Date_____

Which areas are most important for change? Please check:

Attention _____
Focusing_____
Behavior/ Tantrums (describe)_____
Following Directions _____
Motor Skills (describe)_____
Learning_____
Speech (describe)_____
Language (describe)_____
Organizational Skills_____
Reading and Spelling_____
Mathematical understanding_____
Social Skills_____
Flexibility and Transitioning_____
Reduce sensitivities (e.g. tactile, vestibular, auditory, visual, etc.)_____
Emotional Development/ Self-Esteem_____
Memory_____
Sleeping and Eating Patterns_____

Which areas are you ready to improve? Please check:

Listening_____
Social Skills_____
Memory_____
Attention_____
Behavior_____
Reading and Spelling_____
Motor Skills_____

Speaking_____
Critical Thinking_____
Organization_____
Emotional Development_____
Mathematical Understanding_____
Academic Learning_____

Questionnaire completed by_____ Date:_____/___/_____

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Specify as clearly as possible your desired goals:

Fee schedule as of May 2006 / Financial Consent:

Tomatis – Effect Listening Education Program©

Initial consultation (1 ½–2 hours) $195

Cancellation Policy: In order to best serve all of our clients, we ask that you give us **48** hours notice if you must cancel an initial consultation or movement/consultation session. For listening sessions, we ask that you give us **24** hours notice. For missed appointments and no-shows, we will charge 50% of the consultation fee in order to cover our operating costs. We appreciate your understanding on this matter.

By signing this form, I am indicating that I understand and accept the above fee schedule.
Signature: _____ Date: _____