



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 _____ E-mail address _____

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

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

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)

- | | | |
|---------------------------------------|---|-------------|
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Occupational therapist | Other _____ |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Physical therapist | _____ |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Speech therapist | _____ |
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Vision therapist | _____ |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Music therapist | _____ |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Tutor | _____ |
| <input type="checkbox"/> Nutritionist | <input type="checkbox"/> 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	
Plays appropriately with toys	Yes/No/Not sure	younger than their age	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
 Well rested after sleep? Yes/No
 Sleeps from _____ to _____
 Trouble getting to sleep? Yes/No
 Trouble waking up? Yes/No

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"