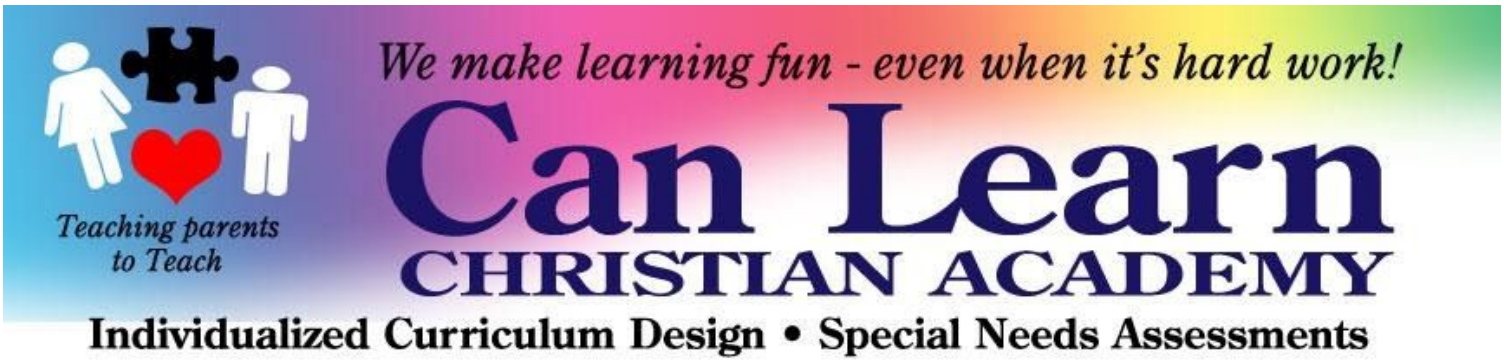

MEDICAL, PHYSICAL AND EDUCATION HISTORY APPLICATION

Please answer all questions completely and honestly. We do ask some personal questions. These questions are not to judge you, but each may provide a clue into your child's struggles.

This information is confidential. We are aware that this is a long history application. Take it a section at a time.

If you have questions filling out the application, please call our office at (509) 326-3418 and our e-mail is: canlearnacademy@gmail.com

Please mail the completed history for along with the deposit to Can Learn Christian Academy PO Box 9233 Spokane, WA 99209

Child's Information	
Today's date	Form filled out by parent ___ guardian __
Child's name	Date of birth Age:
Is child adopted?	If so, at what age?
Is child adopted from US or International? If international what country? _____ Was child in your home as a foster child before adoption?	
Ethnicity: __ White __ African American __ Asian __ Native Am. __ Hispanic __ Other (specify)	
Family Information	
Mother's name	Father's name
Address	Address only if not living with family
Phone (home)	Phone (home)
Phone (work)	Phone (work)
Phone (fax)	Phone (fax)
e-mail	e-mail
Education completed	Education completed
Occupation	Occupation

Siblings:

Name	Age	Birth/Adopted	Name	Age	Birth/Adopted

How did you learn about CAN LEARN? _____

Does the child have a disability or diagnosis? _____

Describe how it impacts his/her daily life_____

_____

_____

_____

Pregnancy and birth information Please answer with yes (y) no (n) or not sure (ns)

During the pregnancy: (If child is adopted fill out what is know and not known for the rest)

Did you receive prenatal care?	Regularly? ☐ Seldom? ☐	Did you smoke?	Yes ☐ No ☐
Did you take prenatal vitamins?	Yes ☐ No ☐	How much per day did you smoke?	
Did you get "morning sickness"?	Yes ☐ No ☐	Did you stop smoking once you discovered you were pregnant?	Yes ☐ No ☐
How many weeks or months were you sick?		Were you regularly exposed to "second hand" smoke?	Yes ☐ No ☐
Did you vomit more then once an hour?	Yes ☐ No ☐	How often?	
Were you hospitalized for any reason?	Yes ☐ No ☐	Did you consume alcohol prior to pregnancy?	Yes ☐ No ☐
Was there ever the threat of miscarriage?	Yes ☐ No ☐	What did you drink?	
Did you have toxemia or eclampsia?	Yes ☐ No ☐	How many drinks a day?	

Did you have gestational diabetes? When did it start? _____	Yes ☐ No ☐	What size glass did you use?	
Did you have high blood pressure? During ____ Before _____		Did you keep "topping" off the glass or refill when empty?	Yes ☐ No ☐
Did you have any surgeries?	Yes ☐ No ☐	Did you stop drinking when you discovered you were pregnant?	Yes ☐ No ☐
Did you have any illnesses?	Yes ☐ No ☐	What and how often?	
Did you have any cravings?	Yes ☐ No		
Did you get leg cramps? How often & beginning in what part of pregnancy?		Did you restart drinking after the baby's birth?	Yes ☐ No ☐
Did you breast feed?	Yes ☐ No ☐	How much per day?	
Are you RH Negative?	Yes ☐ No ☐	Were you taking any medications?	Yes ☐ No ☐
What is the birth order of this child?		What and reason?	
Did you have x-rays or ultrasounds?	Yes ☐ No ☐	What were the effects?	
How many and starting in what month?		Did you or your spouse work around any type of toxic substances or chemicals?	Yes ☐ No ☐
Where was the baby born?	in a hospital ☐ by a midwife ☐ at home? ☐	What and how often?	
Did you work outside the home during pregnancy?	Full time ☐ Part time ☐ Did not work ☐	Did working around these substances affect your health or well being in any way?	Yes ☐ No ☐
What type of work?		Explain. Below	
Did you use perscription or over-the-counter medications during pregnancy?	Yes ☐ No ☐	Did you have problems sleeping? Did you use sleep aids?	Yes ☐ No ☐ Yes ☐ No ☐

Please detail any unusual event or chemical exposure: _____

Type of labor:

Was your labor	Spontaneous? ☐ Induced? ☐	Did you receive an epidural or other medication to help with labor pains?	Yes ☐ No ☐
How long was your labor?		What and at what point of labor?	

Type of delivery: y (yes) n (no) ns (not sure)

Normal?	Yes ☐ No ☐ NS ☐	Premature?	Yes ☐ No ☐ NS ☐
Breech?	Yes ☐ No ☐ NS ☐	How early?	
C-Section?	Yes ☐ No ☐ NS ☐	Birth weight?	
Full term?	Yes ☐ No ☐ NS ☐	Apgar score?	
Forceps?	Yes ☐ No ☐ NS ☐	Was baby wanted and loved?	Yes ☐ No ☐ NS ☐
Suction?	Yes ☐ No ☐ NS ☐	Were you under any extra stress or chaos during the pregnancy?	Yes ☐ No ☐ NS ☐
Dr. break water?	Yes ☐ No ☐ NS ☐	Were there any congenital problems?	Yes ☐ No ☐ NS ☐

Post delivery and complications: y (yes) n (no) ns (not sure)

Cry immediately?	Yes ☐ No ☐ NS ☐	Infection?	Yes ☐ No ☐ NS ☐
Was the cry:	Strong ☐ Weak ☐	Maconmium?	Yes ☐ No ☐ NS ☐
If baby didn't cry immediately, how long until he/s did cry		Did baby aspirate?	Yes ☐ No ☐ NS ☐
Did baby need a ventilator?	Yes ☐ No ☐ NS ☐	Hemorrhage?	Yes ☐ No ☐ NS ☐
How long?		How much and how long?	
Cord around neck?	Yes ☐ No ☐ NS ☐	Cyanosis (turned blue)	Yes ☐ No ☐ NS ☐

Jaundice?	Yes ☐ No ☐ NS ☐	How long?	
How long?		Cerebral bleeding?	
Infant positive on drugs or alcohol?	Yes ☐ No ☐ NS ☐	Intensive care nursery	Yes ☐ No ☐ NS ☐
Which drugs?			
Infant injured during delivery?	Explain:		
Apparent disability or disorder?	Explain		
Sucking problems	Explain:		
Swallowing problems	Explain:		
Were there any congenital problems?			
Other complications:			

Early Infancy: Did your infant: (Note for an adopted child list how child was when first arrived in your home and then write explanation of change over time with your family)

Sleep soundly?	Yes ☐ No ☐ NS ☐	Was infant alert and curious about the world?	Yes ☐ No ☐ NS ☐
Get REM sleep (dream)?	Yes ☐ No ☐ NS ☐	Problems with alertness and responsiveness	Yes ☐ No ☐ NS ☐
Startle easily?	Yes ☐ No ☐ NS ☐	During this period of life experienced health problems?	Yes ☐ No ☐ NS ☐
Non-sleeper?	Yes ☐ No ☐ NS ☐	Body seems listless?	Yes ☐ No ☐ NS ☐
Sleep pattern difficulties?	Yes ☐ No ☐ NS ☐	Need rigid routine?	Yes ☐ No ☐ NS ☐
Did infant sleep on his/her stomach or back?	Back ☐ Stomach ☐	Have regular bowel movements?	Yes ☐ No ☐ NS ☐
How old before sleeping through the night?	Yes ☐ No ☐ NS ☐	Was skin a nice pinkish color?	Yes ☐ No ☐ NS ☐
Cry for no obvious reasons?	Yes ☐ No ☐ NS ☐	Was infant nursed?	Yes ☐ No ☐ NS ☐

During feeding times (bottle or nurse) did infant look at your face or environment?	Yes ☐ No ☐ NS ☐	If so, how long?	
What type of formula was infant on?			

On a scale of 1-10 (1 being horrible 5= so-so and 10 an angel) was infant:|

Easy baby	1 2 3 4 5 6 7 8 9 10	"fussy" baby	1 2 3 4 5 6 7 8 9 10
Average baby	1 2 3 4 5 6 7 8 9 10	Colicky	1 2 3 4 5 6 7 8 9 10
Normal baby	1 2 3 4 5 6 7 8 9 10	Restless baby	1 2 3 4 5 6 7 8 9 10
Difficult baby	1 2 3 4 5 6 7 8 9 10	Excessive restlessness	1 2 3 4 5 6 7 8 9 10
Average Sociable	1 2 3 4 5 6 7 8 9 10	Calm easily	1 2 3 4 5 6 7 8 9 10
More **unsociable** then other infants	1 2 3 4 5 6 7 8 9 10	Not calm by being held, stroked or rocked	1 2 3 4 5 6 7 8 9 10
Very intent when wanted something	1 2 3 4 5 6 7 8 9 10	Enjoy being touched or cuddling?	1 2 3 4 5 6 7 8 9 10
Average insistence when wanted something	1 2 3 4 5 6 7 8 9 10	Stiffened or arched back with touched or cuddled?	1 2 3 4 5 6 7 8 9 10
Not at all insistent when wanted something	1 2 3 4 5 6 7 8 9 10	Excessive number of accidents compared to other children	1 2 3 4 5 6 7 8 9 10
Constantly into everything	1 2 3 4 5 6 7 8 9 10	Would bang head	Yes ☐ No ☐ NS ☐
	1 2 3 4 5 6 7 8 9 10	If yes, how long and often?	

Any additional information:

Medical Information

Family Physician _____ Phone: _____

Address _____

Childhood diseases:

Please check all the childhood diseases your child has experienced and age experienced:

_____age Mumps	_____age Chicken pox
_____age Scarlet fever	_____age Red Measles
_____age Whooping cough	_____age German Measles
_____age Encephalitis	_____age Pneumonia
_____age Persistent high fever	_____age Seizure with fever
_____age Lead poisoning	_____age Seizures without fever
_____age Coma	_____age Other: _____

Yes ☐ No ☐ Did child receive childhood vaccinations/immunizations? At regular ages or later? _____

Yes ☐ No ☐ Did child ever have a negative reaction to any vaccinations/immunizations?

If so, please explain: _____

Yes ☐ No ☐ Did infant/child's development and/or behaviors change after vaccinations/immunizations?

If yes, please explain: _____

_____

_____

Age of client when parent first had concerns about developement _____

Please list any pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date	Examined by	Diagnosis	Recommendations

Yes ☐ No ☐ Period without oxygen? (explain) _____

Yes ☐ No ☐ Trauma to head? (explain) _____

Yes ☐ No ☐ Major fall or concussion? (explain) _____

Yes ☐ No ☐ Been institutionalized? (explain) _____

Yes ☐ No ☐ More than 24 hours separations from caregivers (placements)_____

Yes ☐ No ☐ Been neglected? Major ☐ Moderate ☐ (explain)_____

Yes ☐ No ☐ Been abused? Major ☐ Moderate ☐ (explain)_____

_

Yes ☐ No ☐ Witnessed violence? Major ☐ Moderate ☐
(explain)_____

Other: _____

Yes ☐ No ☐ Any surgeries? Please explain _____

Yes ☐ No ☐ Any history of seizures? Describe: type _____ how often? _____

What medication is currently used? _____

Yes ☐ No ☐ Any history of broken bones? List specifics _____

Yes ☐ No ☐ Does child have Scoliosis or cervical of the spine? _____

Yes ☐ No ☐ Does child have any problems with bones or skeletal system? _____

Yes ☐ No ☐ Does child have any problems with the neck? _____

Yes ☐ No ☐ Is child currently taking any medications? Please list.

Yes ☐ No ☐ Febrile seizure? (from high fever) Explain:

_____

Medication	Dosage	Times per day	how's it working?	Side effects?

Also, describe medications child has taken previously with major side effects.

_____

_____

_____

Yes ☐ No ☐ Are there any medical problems that place limitations on physical activities? Explain

_____

_____

_____

DEVELOPMENTAL MILESTONES At what age did child:

Year/Month	Milestone	Year/Month	Milestone

	Raise head		Start babbling
	Smile		First word (what was it?)
	Giggle		Use of couplets (2 words)
	Laugh out loud		3-4-word phrases
	Push up on arms		Sentences
	Roll over		Conversational language
	Hold bottle		Sing
	Crawl (on stomach)		Use rhyming words
	Creep (on hands & knees)		Drink from a straw
	Sit alone Drink from cup		Use utensils
	Hold cup		Transfer objects between hands
	Drink from cup		Play Peek-a-boo
	Feed self finger food		Clap hands
	Walk (toddle walk)		Play Patty Cake
	Walk		Wave Bye-Bye (open/close hand)
	Run		Wave Bye-Bye (real wave)
	Climb on furniture		Scribble on paper with back-forth motion
	Climb stairs one foot at a time		Scribble in circles and loops
	Climb stairs alternate feet		Able to trace lines
	Jump up and down both feet		Able to color within the lines
	Toilet train		Able to print name

Self-Help Skills

On a scale of 1-6 (1=unable 10= mastered) please rate child's self-help skills

Dress independently	1 2 3 4 5 6 7 8 9 10	Brush Teeth	1 2 3 4 5 6 7 8 9 10
Shirt	1 2 3 4 5 6 7 8 9 10	Wash Self in Tub	1 2 3 4 5 6 7 8 9 10
Pants	1 2 3 4 5 6 7 8 9 10	Wash Hands	1 2 3 4 5 6 7 8 9 10
Shoes	1 2 3 4 5 6 7 8 9 10	Use eating utensils	1 2 3 4 5 6 7 8 9 10
Underclothes	1 2 3 4 5 6 7 8 9 10	Cut food with knife	1 2 3 4 5 6 7 8 9 10
Jacket	1 2 3 4 5 6 7 8 9 10	Tie shoes	1 2 3 4 5 6 7 8 9 10
Brush Own Hair	1 2 3 4 5 6 7 8 9 10	Button items	1 2 3 4 5 6 7 8 9 10
Brush Teeth	1 2 3 4 5 6 7 8 9 10	Unbutton items	1 2 3 4 5 6 7 8 9 10

Describe the child's diet

How often does child eat (list favorites)	**Excessive**	**Daily**	**3 x week**	**1x week**	**Never**
Our family eats a vegetarian diet _____					

Our family eats a vegan diet _____					
Vegetables					
Fruits					
Meats					
Sugars					
Artificial sweeteners					
Artificial colorings					
Caffeine drinks					
"Cured" lunch meat					
Dairy products					
White flour					

Yes ☐ No ☐ Does child have an active 'gag reflex' (gag easily)?

What trigger's it? _____

_____

Does child over-eat? Yes ☐ No ☐ Always? Yes ☐ No ☐ Until he/s vomits? Yes ☐ No ☐ Favorite foods only?

Yes ☐ No ☐ Have poor appetite?	Yes ☐ No ☐ Never hungry?
Yes ☐ No ☐ Too busy to eat?	Yes ☐ No ☐ Rushes through eating?
Yes ☐ No ☐ Does child chew with mouth open?	

Yes ☐ No ☐ Has child ever taken Acidophilus (regular yogurt or Probiotics?

How much plain water does child drink daily?

☐ Not unless made ☐ 1-2 glasses ☐ 3-4 glasses ☐ more then 5 8oz. glasses? ☐ Only in juice, etc

Yes ☐ No ☐ Are you aware of any food intolerances?	What?

Yes ☐ No ☐ Are you aware of any food allergies? (allergies are different from intolerances)

Yes ☐ No ☐ Does child crave food? What and how often?

Yes ☐ No ☐ Does child take any dietary supplements and/or vitamins? Please list: (what and brand)

_____

_____

_____

Yes ☐ No ☐ Is child a picky eater? Due to: ☐ Smell ☐ Texture ☐ Taste ☐ Temperature ☐ Looks

If so, what and how often?

Yes ☐ No ☐ Any other cravings? What?

Yes ☐ No ☐ Does child get stomachaches? ☐ Shortly after eating ☐ occasionally ☐ never ☐ regularly

Yes ☐ No ☐ Does child regularly have problems with 'gas' after eating? Is it? ☐ smelly ☐ loud

Yes ☐ No ☐ Does child's behavior change shortly after eating?

What was eaten? _____ How does behavior change? _____

Yes ☐ No ☐ Do child's ear lobes turn red

Yes ☐ No ☐ Get white spots on cheeks?

Yes ☐ No ☐ Dark circles under eyes?

Yes ☐ No ☐ Does child have regular bowel movements?

Yes ☐ No ☐ 1-2 daily

Yes ☐ No ☐ Does child have problems holding urine?

Yes ☐ No ☐ Does your child ever smell like fresh bread baking while in the bathtub?

Yes ☐ No ☐ Does child have a whitish coating on tongue?

Yes ☐ No ☐ To the point its hard to see his/her taste buds

Yes ☐ No ☐ Slightly

Yes ☐ No ☐ Does child get frequent cold sores, boils or rashes on the skin?

GENETIC FAMILY Questions

Yes ☐ No ☐ Irritable bowel	Yes ☐ No ☐ Celiac	Yes ☐ No ☐ Auto Immune
Yes ☐ No ☐ Crones	Yes ☐ No ☐ Arthritis	Yes ☐ No ☐ Kidney
Yes ☐ No ☐ Diabetes	Yes ☐ No ☐ Heart Disease	Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Lupus	Yes ☐ No ☐ MS	Yes ☐ No ☐ Autism
Yes ☐ No ☐ Asthma	Yes ☐ No ☐ Addictions	Yes ☐ No ☐ Mental Illness

SENSORY SYSTEM AUDITORY	AVOIDS	SEEKS	MIXED	NO PROBLEM
Hearing loud sounds such as car horns, alarms, sirens, loud music, or TV				
Being in noisy setting such as a crowded restaurant, party, classroom, or busy store				
Watching TV or listening to music at very high or very low volume				
Speaking or being spoken to amid other sounds or other voices				
Background noise when concentrating on a task (other voices, music, dishwasher, fan)				
Games with rapid verbal instructions such as Simon Says or Hokey Pokey				
Back-and-forth, interactive conversation				
Unfamiliar sounds, silly voices, foreign languages				
Singing alone or with others				
Making noise just to hear noise				
Does child have a history of ear infections or congestion? Yes ☐ No ☐ NS ☐				
Does child have a history of colds or sinus problems? Yes ☐ No ☐ NS ☐				
Pause before answering questions? Yes ☐ No ☐ NS ☐				
Answers frequently have little relation to question? Yes ☐ No ☐ NS ☐				
Answers questions with "because" or simply "yeah"? Yes ☐ No ☐ NS ☐				
Does (did) the child have tubes in ear (s)? Yes ☐ No ☐ Did they help? Yes ☐ No ☐ NS ☐				
Has the child had any recent ear infections? Yes ☐ No ☐ NS ☐				
Passes routine hearing screenings. Yes ☐ No ☐ NS ☐				
Is there any hearing lose? Yes ☐ No ☐ NS ☐				
Has the child had an ABR, tympanogram, or audiogram (hearing test)? Yes ☐ No ☐ NS ☐				

VISION	AVOIDS	SEEKS	MIXED	NO PROBLEM
Looking at shiny, spinning, or moving objects				
Activities that require eye-hand coordination such as catch, stringing beads, writing, and tracing				
Tasks requiring visual analysis such as puzzles, mazes, and hidden pictures				
Activities that require discriminating between colors, shapes, and sizes				
Visually busy places such as stores and playgrounds with a lot of children running				
Finding objects such as socks in a drawer or a particular object on a shelf				
Very bright lights or sunshine, snow, or being photographed with a flash				
Dim lighting, shade, or the dark				
Action-packed, colorful TV, movies, or computer/video games				
New visual experiences such as looking through a kaleidoscope or colored glasses				
Does child enjoy watching TV?				
Does child 'sensory' play flapping hands to side of head?				
Has the ever had an eye examination? Yes ☐ No ☐ NS ☐				
Has the child a visual problem that cannot be corrected with glasses? Yes ☐ No ☐ NS ☐				
Has the child been diagnosed with a visual processing disorder? Yes ☐ No ☐ NS ☐				
Does the child wear glasses? Yes ☐ No ☐ For distance or near point?				
When reading alone does he/s hold the book near or far from face? Near ☐ Far ☐				
Does child enjoy watching TV, playing video/computer games? Yes ☐ No ☐				
Does child enjoy near point activities (sewing, stitchery, etc) Yes ☐ No ☐ NS ☐				
Does child enjoy being read to? Yes ☐ No ☐ NS ☐				
Has child had vision therapy? Yes ☐ No ☐ NS ☐ If so, may we have a copy of the report? Yes ☐ No ☐				

Do you feel it was beneficial? Yes ☐ No ☐ NS ☐ Why or why not? _____

Has the child had any eye surgeries? Yes ☐ No ☐ NS ☐
If yes, please explain:

Has the child been diagnosed with any of the following?
☐ Near-sighted ☐ far-sighted ☐ Macular problems ☐ Glaucoma ☐ Lazy eye ☐ myopia

☐ Cataracts ☐ Lazy eye ☐ Right ☐ Left ☐ Both ☐ Astigmatism ☐ Right ☐ Left ☐ Both ☐ Strabismus -- eye or eyes turn: ☐ inward ☐ outward

VESTIBULAR (MOVEMENT AND BALANCE) add notes if you like	**AVOIDS**	**SEEKS**	**MIXED**	**NO PROBLEM**
Being moved passively by another person (rocked, or twirled by adult, pushed in wagon)				
Riding Equipment that moves through space (swings, teeter-totter, escalators, and elevators)				
Spinning activities (carousels, spinning toys, spinning around in circles)				
Activities that require changes in head position (such as bending over sink) or having head upside down (such as somersaults, hanging from feet)				
Challenges to balance such as skating, bicycle riding, skiing, and balance boards				
Climbing or descending stairs, slides, and ladders				
Being up high such as at top of slide or on mountain overlook				
Less stable ground surfaces such as deep pile carpet, grass, sand, snow or uneven sidewalks/streets				
Riding in a car or other form of transportation: In backseat only? In front-seat only?				

Prefer fast to slow movements? Yes ☐ No ☐ NS ☐

Runs rather then walk? Yes ☐ No ☐ NS ☐

Always needs to be moving (hyperactive)? Yes ☐ No ☐ NS ☐

Can child change directions and movement quickly? Yes ☐ No ☐ NS ☐
Chronic low energy, “lazy”, no motivation (hypoactive)? Yes ☐ No ☐ NS ☐

TASTE AND SMELL	AVOIDS	SEEKS	MIXED	NO PROBLEM
Smelling unfamiliar scents				
Strong odors such as perfume, gasoline, cleaning products				
Smelling objects that aren’t food such as plastic items, Play-Doh, garbage				
Eating new foods				
Eating familiar foods				
Eating strongly flavored foods (very spicy, salty, bitter, or sweet)				

TOUCH	AVOIDS	SEEKS	MIXED	NO PROBLEM
Being touched on some part of the body, hugs, cuddles, or simply bumped				
Certain clothing (including bed cloths and sheets/blankets) fabrics, seams, tags, waistbands, cuffs, etc.				
Clothing, shoes, or accessories that are very tight or very loose				
Getting hands, face, or other body part messy with paint, glue, sand, food, lotion, etc.				
Grooming activities such as face and hair washing, brushing, cutting, shampooing, nail trimming, or tooth brushing				
Taking a bath, shower, or swimming				
Getting towel dried				
Trying new foods				
Eating particular food textures: chewy, crumbly, smooth, mush, crunchy				
Standing close to others				
Walking barefoot				

Does child prefer certain types of paper to write or draw on? Yes ☐ No ☐ NS ☐				

PROPRIOCEPTION (BODY SENSE)	AVOIDS	SEEKS	MIXED	NO PROBLEM
Activities such as roughhousing, jumping, banging, pushing, bouncing, climbing, hanging, and other active play				
High-risk play (jumps from extreme heights, climbs tall trees, rides bicycle over gravel)				
Fine motor tasks such as writing, drawing, closing buttons and snaps, attaching pop beads, and attaching building toys, and other tasks requiring manual dexterity and coordination				
Activities requiring physical strength and force				
Crunchy foods (pretzels, dry cereal) or chewy foods (meat, caramels)				
Smooth, creamy foods (yogurt, cream cheese, pudding)				
Having eyes closed or covered				
Collars, necklaces, ties around neck				
Knows when he has eaten enough (feels full)? Yes ☐ No ☐ NS ☐				
Never/seldom hungry or thirsty? Yes ☐ No ☐ NS ☐				
Fidgets and shifts position when sitting or standing? Yes ☐ No ☐ NS ☐				
Chews with mouth open, slurps, smack lips, or dribbles while drinking? Yes ☐ No ☐ NS ☐				
Picky eater`? Yes ☐ No ☐ NS ☐				
Hears request but can't get body to react? Yes ☐ No ☐ NS ☐				
Has broken bones and not be aware of the pain? Yes ☐ No ☐ NS ☐				
Has had ear infections to the point the ear drum burst before feeling the pain? Yes ☐ No ☐ NS ☐				
Props body on one arm when working at the table? Yes ☐ No ☐ NS ☐				
Yawns a lot although not sleepy? Yes ☐ No ☐ NS ☐				
Rocks back and forth? Yes ☐ No ☐ NS ☐				
Rocks side to side? Yes ☐ No ☐ NS ☐				
Stretches or pushes off from furniture to stand up? Yes ☐ No ☐ NS ☐				
Unable to relax? Yes ☐ No ☐ NS ☐				
Slow response time? Yes ☐ No ☐ NS ☐				

Unaware of surroundings around him/her? Yes ☐ No ☐ NS ☐

Emotional Communications and Social Skills

Emotional communication is the internalized learned behavior, while social are the outward acceptable behaviors. If Emotional communication is low so are social skills.

Is child:	**Always 80%**	**Regularly 50-75%**	**Seldom 40-50%**	**Never <40%**	**Is child:**	**Always 80%**	**Regularly 50-75%**	**Seldom 40-50%**	**Never <40%**
Emotional Communication					**Social Skills**				
Alert and aware of surroundings					Sense of belonging				
Engage in relationships (family)					Make eye contact				
Engage in relationships with siblings					Interact with others				
Know how to form relationships					Enjoy cuddling or hugs				
Carry on simple conversations with one other person					Have transitional objects (blanket, toy)				
Answer just yes, no, because or I don't know to questions					Sense of family unit				
Interact purposely (be a real participant in activity or conversation)					Learning to wait				
Have a sense of who he/s is					Show modesty				
Create ideas to convey current needs					Learning appropriate manners				
Have simple problem-solving skills					Learning native culture/traditions				
Have complex problem-solving skills					Family religious beliefs				
Have a sense of power					Sense of order				

Create ideas to convey intentions					Self help skills				
Create logical bridge between ideas					Personal hygiene				
Able to identify basic feelings/emotions					Cleanliness				
Is child:	**Always 80%**	**Regularly 50-75%**	**Seldom 40-50%**	**Never <40%**	**Is child:**	**Always 80%**	**Regularly 50-75%**	**Seldom 40-50%**	**Never <40%**
Able to identify basic need					Sense of others (they aren't the center of universe!)				
Able to express basic need					Follow family rules				
Able to identify more complex feeling/emotions					Sense of compassion				
Able to express more complex feelings/emotions					Can take turns				
Able to identify more complex need					Has some degree of patience				

Able to express more complex need					Sense of sympathy				
Sense of independence					Able to cooperate				
Sense of separation					Group interaction				
Simple abstract thinking					Sense of order				
Higher level abstract thinking					Self help skills				
Sense of interdependence					Appreciate nature				
Have logical reasoning					Appreciate music				

Humor					Appreciate art				
Knock-knock jokes					Believe in self and abilities				
Purposely misname objects/people					Building independence				
Understand and uses puns/double meanings					Able to do simple chores (list)				
Can tell ready made jokes					1.				
Friendships					2.				
Enjoys playing with others					3.				
Knows how to be a friend									
Making true friendships					Able to do complex chores				
Is child:	**Always 80%**	**Regularly 50-75%**	**Seldom 40-50%**	**Never <40%**	**Is child:**	**Always 80%**	**Regularly 50-75%**	**Seldom 40-50%**	**Never <40%**
Sense of empathy					2.				
Understands rules of games					3.				
Able to be of service to others (volunteer)					Able to be alone (doesn't always need others around)				
Understand group dynamics					Developing hobby/interests				
Able to wait urn									

Stressed behaviors:

How does his/her behavior change when becoming overwhelmed? _____

_____

Yes ☐ No ☐ When child cries are there tears? Are they real tears or for control/manipulation? _____

Yes ☐ No ☐ Does child 'meltdown' into a 'rage'?

If so, does he/s uncontrollably ☐ cry (weep) ☐ scream ☐ cuss

☐ hurt self ☐ (bite, pinch, cut, _____)

☐ hurt others ☐ (bite, pinch, cut, _____)

☐ harm animals or property ☐ Try to runaway

When child rages, what do **you** do? _____

How long does he/s generally rage? _____

What are your emotions/feelings after child rages? _____

Yes ☐ No ☐ Can child get him/herself out of the rage?

-- Instead of raging does child 'shutdown' not expressing their anger and will 'get even' with the other person later?_____

What is child's behavior like after raging (the next day or so)? _____

Yes ☐ No ☐ Can child calm him/herself? _____

Yes ☐ No ☐ Is he/s afraid of the dark, animals or certain noises? ____

If so, what?

_____

Yes ☐ No ☐ Does child hoard food? If so, what?

_____

Yes ☐ No ☐ Is child sneaky taking things that doesn't belong to him/her?

_____

Yes ☐ No ☐ Does child 'pee out their anger'? Where usually? _____

Yes ☐ No ☐ Does he/s wake up during the night? Roam around the house? Yes ☐ No ☐

Yes ☐ No ☐ Have night terrors? How often? _____

Yes ☐ No ☐ Wet the bed? How often_____

Behavioral Characteristics

Is or does child	Constant 75%+	Sometimes >40%	Not a concern	Is or does child	Constant 75%	Sometimes >40%	Not a concern
Low tolerance or easily frustrated				A "black & White" thinker			
Depressed or lonely				Need to 'control' everything			
Hyperactive				Needs to manipulate their world			
Chronically angry or resentful				Know HOW to play			
Blames others for his mistakes or behavior				Understand cause-effect			
Fidgets or always moving				Short term memory problems			
Spiteful and vindictive				Remembers one out of three things			
Been physically or sexually abused				Forgets events or schedules			
Chronically tired				A bully to others			
Anxious				Organized			
Inflexible-explosive behavior (rage or meltdown)				Immediate answer to most any question is "I can't" or "I don't know"			
Have few or no friends				Able to complete tasks, projects or assignments			
Overly argumentative with peers/adults				Defies or refuses to comply with adults' requests or rules			
Unable to follow through or complete tasks				Outgoing, class clown			
Difficulty storing information				Can't stop behavior once started			
Difficulty integrating information				Hears request but can't get body to react			
Difficulty retrieving information				Can tell how to do something but unable to do it			

Easily influenced by peers				Put thoughts into words			
Unable to understand information as a whole when learned that information in smaller pieces (behavior or academic)				Understands one piece but not the whole picture			
Applying social rules in right situation				Doesn't know when he's hot or cold			

Is or does child	**Constant 75% +**	**Sometimes > 40%**	**Not a concern**	**Is or does child**	**Constant 75%**	**Sometimes > 40%**	**Not a concern**
Meaningful problem solving				Dresses inappropriate for weather conditions/predictions			
Unable to stop activity when asked				Actions and consequences not connected			
Reacts with anger when interrupted				Trouble planning			
Needs more time to finish				Trouble getting started with task			
Distinguish danger from safety				Upset when rules change n			
Sound like they understand but don't				Upset when environment changes			
Difficulty filtering auditory stimuli				Physically or verbally aggressive			
Passes routine hearing screenings				Deliberately annoys others			
Difficulty filtering visual stimuli				Often touchy or easily annoyed by others			
Passes routine vision screenings				Limited flexibility and adaptability			
Can state rule but unable to obey it				Doesn't seem to learn from consequences			
Slow thinker				Have high pain tolerance			
Slow response time				Unable to relax			
Fidgets to listen				Body tense/stiff			

Runs rather then walk				Hate tags in clothes			
Bumps into furniture or walls while walking				Hates face or hair washed or messed with			
Wraps legs around chair legs as if holding on for dear life				Hates things around neck			
Does child prefer certain types of paper to write or draw on				Know when he eaten enough (feels full)			
Has child ever mentioned not liking to touch certain types of paper				Never/seldom hungry or thirsty			
Does child squint when looking at newsprint				Chews with mouth open, slurps, smack lips, or dribbles while drinking			
Does child squint when looking at notebook paper				Picky eater`			
Is or does child	**Constant 75%+**	**Sometimes >40%**	**Not a concern**	**Is or does child**	**Constant 75%**	**Sometimes >40%**	**Not a concern**
Does child squint when looking at printer paper				Prefer fast to slow movements			
Stretches or pushes off from furniture to stand up				Able to skip			
Rocks back and forth				Able Ride a bicycle			
Rocks side to side				Able Roller skate			
Unaware of surroundings around him/her				Pause before answering questions			
Can child carry on a conversation				Answers frequently have little relation to question			
Answers questions with “because” or simply “yeah”				Startles with sudden loud noises, sudden appearance of something, or when imbalance.			

HAND PREFERENCE

	Right	Left	Mixed
Write	____	___	____
Eat	____	___	____
Throw	____	___	____
Brush teeth	____	___	____
Comb hair	____	___	____
Scissors	____	___	____

Mother hand preference _____ (if child is your biological)
Father hand preference _____ (if child is your biological)

List ant labels, diagnosis, or classifications _____

_____

List any educational problems (past or present)

_____

_____

_____

Lessons (musical, physical/sports, art, languages, etc)

_____

_____

_____

List any exceptional abilities the child has:

_____

_____

_____

_____

Yes ☐ No ☐ Is the child seeing any type of specialist? What type and reason?

_____

Describe the child's daily level of physical activity_____

How much time does child spend watching TV and/or playing video/computer games per day?

_____

How much time does child spend on computer per day? _____

List **FOUR** positive things about your child:

1. _____ 3. _____
2. _____ 4. _____

List **TWO** negative things about your child:

1. _____ 2. _____

Please describe any problems in managing your child's behavior. _____

_____

What activities do you do with your child per day? _____

If you work outside the home how much time do you spend with your child per week? _____

Please describe the discipline strategies you have used to manage your child's behavior problems. _____

_____

_____

_____

How are your strategies working for you? _____

Education and learning

Reading, writing and spelling		**MATH RELATED**	
Remembers nursery rhymes	Yes/no/not sure	Recognize numerals quickly	Yes/no/not sure
Understands what is read with pictures	Yes/no/not sure	Understands number values	Yes/no/not sure
		Recognize quantities in groups without counting?	Yes/no/not sure
Understands what is read to him/her	Yes/no/not sure	Able to do mental math	Yes/no/not sure
Understands general idea of a story	Yes/no/not sure	Poor understanding of concepts	Yes/no/not sure
Understands general idea of movie	Yes/no/not sure	Poor math facts	Yes/no/not sure
Comprehends read material	Yes/no/not sure	Counts on fingers	Yes/no/not sure

Poor understanding of phonics	Yes/no/not sure	Able to do Word problems	Yes/no/not sure
Understands verbal instruction/directions	Yes/no/not sure	Poor logic	Yes/no/not sure
Understands written instruction/directions	Yes/no/not sure	Understands money	Yes/no/not sure
Does child skip lines while reading?	Yes/no/not sure	Able to use learned information in daily life	Yes/no/not sure
Does child move head from left to right while reading?	Yes/no/not sure	**THINKING RELATED**	
Quickly identifies letters?	Yes/no/not sure	Visualization (thinks in pictures)	Yes/no/not sure
Uppercase?	Yes/no/not sure	Play visual memory games?	Yes/no/not sure
Lowercase?	Yes/no/not sure	Conceptualizing (thinks in words)	Yes/no/not sure
Both?	Yes/no/not sure	Long term memory	Yes/no/not sure
Do 'hidden picture' puzzles?	Yes/no/not sure	Short term memory	Yes/no/not sure
Reverse letters	Yes/no/not sure	Abstract thinking	Yes/no/not sure
Reverse words	Yes/no/not sure		
Reverse numerals	Yes/no/not sure		
Reverse symbols	Yes/no/not sure		
Head rotate to follow hand while printing	Yes/no/not sure	**MEMORY SKILLS**	
Difficulty copying from book or blackboard	Yes/no/not sure	Does child remember stories If stopped will child start over from the beginning?	Yes/no/not sure
		Does child remember facts	Yes/no/not sure
Difficulty copy paper to paper	Yes/no/not sure	Does child remember events	Yes/no/not sure
Cannot put thoughts in writing	Yes/no/not sure	Can child recall things in the past but not recent	Yes/no/not sure
Poor or non-composition skills	Yes/no/not sure	Can child recall recent things but not from the past	Yes/no/not sure
Poor pencil grasp	Yes/no/not sure	What is child's attitude toward school and learning?	
Sloppy writing	Yes/no/not sure		
Color neatly/stay in lines?	Yes/no/not sure		

Poor speller	Yes/no/not sure	
Types using correct fingering	Yes/no/not sure	

Cleaners and body products

Sometimes products we use around the house or on our body affect the brain. What brand of cleaning products do you use around the home?

- Laundry? _____
- Softener? _____
- Bleach or other stain remover? _____
- Dishes? _____
- Floors (mop)? _____
- Floors (shine)? _____
- To clean carpets? _____
- To deodorize carpets. _____
- Wash windows? _____
- Bathroom cleaners (sink & tub)? _____
- Toilet? _____
- Bathing? _____
- Shampoo? _____
- Bubble bath? _____
- Deodorant? _____

Do you use essential oils? Yes No

Which ones? _____

Reason used?_____ _____

Goals and Plans

What are your goals and expectations? _____

_____
_____
_____
_____

Who will implement the program? _____

Daily length of time parents can work with the client? _____

Daily length of time others can work with client? _____

How'd you hear about Can Learn? _____

Can Learn Christian Academy is an organization of parents and professionals dedicated to assisting individuals in the achievement of their innate God given potentials. Can Learn is continually investigating, researching and utilizing the best methods available in this endeavor. Program recommendations are not medical, therapeutic, or psychological prescriptions. Program recommendations are offered for the client and family's review investigation and education. Application of said procedures is the responsibility of the client and family. Toni Hager, (founder of Can Learn), is a mother and Neurodevelopment Specialist. She does not, nor is she 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 neither Can Learn nor those trained by or employed by Can Learn are assuming responsibility or liability for the client, and that I, as parent, guardian, or client, assume full responsibility.

Signature _____Date_____

Signature _____Date_____

Thank you for taking the time to provide more insight into your child's struggles!