



Liberty Consultants

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Please attach
recent photo
of client

APPLICATION FORM – CHILD

Client's Name _____ Today's Date _____
Address _____ Date of birth _____
_____ Home Phone _____
City _____ Work Phone _____
State _____ Zip _____ Fax _____
Is the client adopted? Yes No If yes, at what age? _____
From what country? _____



Father's Name _____ Date of birth _____
Address (if different than client's) _____ Home Phone _____
_____ Work Phone _____
City _____ Fax _____
State _____ Zip _____ Education completed _____
Email _____ Occupation _____

Mother's Name _____ Date of birth _____
Address (if different than client's) _____ Home Phone _____
_____ Work Phone _____
City _____ Fax _____
State _____ Zip _____ Education completed _____
Email _____ Occupation _____

Preferred Family Contact Information:

Phone (primary) _____
Phone (secondary) _____
Email _____



Office
Code _____

Have you listened to the Brain Power Tap Into It CD's? Yes / No
Who shared with you about Liberty Consultants? _____

Family History:

Sibling Name _____ Date of Birth _____ On program? Yes No

Sibling Name _____ Date of Birth _____ On program? Yes No

Sibling Name _____ Date of Birth _____ On program? Yes No

Sibling Name _____ Date of Birth _____ On program? Yes No

Sibling Name _____ Date of Birth _____ On program? Yes No

Difficulty with parents? Yes/No *If yes, please explain:* _____

Difficulty with siblings? Yes/No *If yes, please explain:* _____

History of emotional or mental illness in family? Yes/No *If yes, please explain:* _____

Medical History

Length of pregnancy: _____ Weight at birth: _____ lbs. _____ oz.

Complications at birth? Yes/No *If yes, please explain:* _____

Please list relative medical, therapeutic and neurological testing:

| <i>Date</i> | <i>Examination</i> | <i>Physician</i> | <i>Recommendations</i> |
|-------------|--------------------|------------------|------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Does the client have history of:

- Congestion and/or sinus infections? Yes/No
- Ear infections? Yes/No *If yes, which ears?* _____
- Tinnitus? Yes/No *If yes, which ears?* _____
- Allergies? Yes/No *If yes, please list.* _____
- Seizures? Yes/No *If yes, please explain. List medication.* _____

Is the client taking medicine or supplements? Yes/No *If yes, please list with purpose.* _____

Has the client had a broken bone? Yes/No *If yes, please explain.* _____

Has the client had surgery? Yes/No *If yes, please explain.* _____

Any medical problems which limit physical activity? Yes/No *If yes, please explain.* _____

Visual/Auditory History

Has the client had an eye examination? Yes/No *If yes, what were results?* _____

Does the client wear glasses/contacts? Yes/No *If yes, what prescription?* _____

Has the client had vision therapy? Yes/No *If yes, when and results* _____

Does the client have any of the following (*circle all that apply*):

- ◆ Nearsighted ◆ Glaucoma ◆ Light sensitivity ◆ Amblyopia ◆ Nystagmus
- ◆ Farsighted ◆ Hyper peripheral ◆ Color blindness ◆ Strabismus ◆ Cataracts
- ◆ Astigmatism ◆ Macular problems ◆ Cortical Blindness ◆ Other: _____

Does the client enjoy watching TV? Yes/No Distance from TV screen: _____

Does the client enjoy reading? Yes/No Being read to? Yes/No

Has the client had a tympanogram? Yes/No *If yes, when and what were results?* _____

Does the client have hearing loss? Yes/No *If yes, please explain.* _____

Does the client have hypersensitive hearing? Yes/No *If yes, please explain.* _____

Does the client have tinnitus? Yes/No *If yes, please explain.* _____

Developmental History

Please fill in age of the client (*child's age: i.e. 1 year 2 months*):

- | | | | |
|-----------------------|------------------------|------------------|------------------------|
| ◆ Crawled (tummy) | Year _____ Month _____ | ◆ First Word | Year _____ Month _____ |
| ◆ Crept (hands/knees) | Year _____ Month _____ | ◆ Couplets | Year _____ Month _____ |
| ◆ Walked | Year _____ Month _____ | ◆ 3-4 wd Phrases | Year _____ Month _____ |
| ◆ Ran | Year _____ Month _____ | ◆ Converse | Year _____ Month _____ |
| ◆ Toilet Trained | Year _____ Month _____ | ◆ Read | Year _____ Month _____ |

Has client had bedwetting issues within the last year? Yes/No

Areas of concern (*Please circle all that apply*):

- ◆ Speech/language ◆ Fine motor ◆ Right/Left Confusion ◆ Mirror writing
- ◆ Articulation ◆ Gross motor ◆ Forgetful ◆ Sloppy writing
- ◆ Stammer/Stutter ◆ Poor judge of time ◆ Poorly organized ◆ Difficulty copy from board

Please list educational, developmental or psychological testing or diagnosis:

| Date | Educ./Dev. Exam/Test | Recommendations |
|------|----------------------|-----------------|
| | | |
| | | |
| | | |

Educational History

Schools/academic programs with years attended, grade completed and degrees earned:

Current grade and school/homeschool: _____

List any education problems, labels, classifications or educational diagnoses. _____

Has the client taken standardized tests? Yes/No *If yes, please summarize experience for client.* _____

Does the client struggle with the following academic skills:

- | | | | |
|--------------------|-----------------|----------------------|-----------------|
| ◆ Reading ability | Yes/No/Not sure | ◆ Math computation | Yes/No/Not sure |
| ◆ Letter reversals | Yes/No/Not sure | ◆ Math concepts | Yes/No/Not sure |
| ◆ Logic problems | Yes/No/Not sure | ◆ Math word problems | Yes/No/Not sure |

Nutritional History

Please describe client's diet: _____

Check how often the client eats the following:

| | Craves | Daily | Weekly | Monthly | Rarely | Never |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Dairy | <input type="checkbox"/> |
| Meat | <input type="checkbox"/> |
| Fresh fruit | <input type="checkbox"/> |
| Vegetables (Cooked) | <input type="checkbox"/> |
| Vegetables I (Raw) | <input type="checkbox"/> |
| Sugar | <input type="checkbox"/> |
| Sweeteners / Preservatives | <input type="checkbox"/> |
| White flour | <input type="checkbox"/> |
| Artificial color/flavor | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> |

Food allergies? Yes/No/Never tested *If yes, please explain.* _____

Food cravings? Yes/No *If yes, please explain.* _____

Picky eater? Yes/No *If yes, please explain.* _____

Overweight or underweight? Yes/No *If yes, please explain.* _____

How often has the client been on antibiotics? _____

History of yeast infection? Yes/No *If yes, please explain.* _____

Dietary supplements and Vitamins _____

Behavioral History

Does the client have history of emotional or behavioral disorders? Yes/No *If yes, please explain* _____

Describe client's positive behaviors: _____

Describe client's negative behaviors: _____

Are there any circumstances that may currently affect the client's behavior? Yes/No *If yes, Please explain* _____

Does the client struggle with:

| | | | |
|---------------------------------|------------------------|------------------------------|------------------------|
| academic fluctuation | <i>yes/no/not sure</i> | low frustration level | <i>yes/no/not sure</i> |
| aggressive behavior | <i>yes/no/not sure</i> | obedience | <i>yes/no/not sure</i> |
| avoidance behavior | <i>yes/no/not sure</i> | overly sensitive to odor | <i>yes/no/not sure</i> |
| competitive | <i>yes/no/not sure</i> | overly sensitive to sound | <i>yes/no/not sure</i> |
| compliance/cooperation | <i>yes/no/not sure</i> | overly sensitive to touch | <i>yes/no/not sure</i> |
| destructive behavior | <i>yes/no/not sure</i> | overly sensitive emotionally | <i>yes/no/not sure</i> |
| difficulty following directions | <i>yes/no/not sure</i> | overreacts | <i>yes/no/not sure</i> |
| difficulty with teachers | <i>yes/no/not sure</i> | organization | <i>yes/no/not sure</i> |
| difficulty with peers | <i>yes/no/not sure</i> | pain tolerance high | <i>yes/no/not sure</i> |
| distractibility | <i>yes/no/not sure</i> | pain tolerance low | <i>yes/no/not sure</i> |
| disorganized | <i>yes/no/not sure</i> | perseverates (talk on topic) | <i>yes/no/not sure</i> |
| emotionality | <i>yes/no/not sure</i> | phobias | <i>yes/no/not sure</i> |
| few or no friends | <i>yes/no/not sure</i> | short attention span | <i>yes/no/not sure</i> |
| flexibility | <i>yes/no/not sure</i> | social | <i>yes/no/not sure</i> |
| hyperactive | <i>yes/no/not sure</i> | socially immature | <i>yes/no/not sure</i> |
| hypoactive | <i>yes/no/not sure</i> | sucks thumb | <i>yes/no/not sure</i> |
| impulsive | <i>yes/no/not sure</i> | temper tantrums | <i>yes/no/not sure</i> |
| inconsistent achievement | <i>yes/no/not sure</i> | tics | <i>yes/no/not sure</i> |

Therapy History

Is the client seeing a specialist? Yes/No (Please circle all that apply)

- | | | | |
|----------------------------|--------------------------|----------------------|--------------------|
| ◆ Cardiologist | ◆ Music Therapist | ◆ Orthopedist | ◆ Speech Therapist |
| ◆ Chiropractor | ◆ Neurologist | ◆ Osteopath | ◆ Tutor |
| ◆ Counselor | ◆ Nutritionist | ◆ Physical Therapist | ◆ Vision Therapist |
| ◆ Cranial Sacral Therapist | ◆ Occupational therapist | ◆ Psychologist | ◆ Other |

Accomplishments

Is the client taking any classes or lessons for extracurricular activities? Yes/No

List exceptional abilities including academic, artistic, musical and physical: _____

Physical Skills History

Do you have concerns for the client in any of the following areas: *(circle those that apply)*

- ◆ Athetoid movement
- ◆ Ataxic
- ◆ Balance
- ◆ Coordination
- ◆ Crawling
- ◆ Creeping
- ◆ Muscle tone low
- ◆ Muscle tone high
- ◆ Running
- ◆ Walking
- ◆ Weakness
- ◆ Other: _____

What is the client's hand-preference for the following activities: *(Please circle the appropriate hand)*

| | | | |
|----------------|------------------------|----------|------------------------|
| Brushing teeth | <i>Rt / Lf / Mixed</i> | Throwing | <i>Rt / Lf / Mixed</i> |
| Combing hair | <i>Rt / Lf / Mixed</i> | Writing | <i>Rt / Lf / Mixed</i> |
| Computer mouse | <i>Rt / Lf / Mixed</i> | Other: | <i>Rt / Lf / Mixed</i> |
| Eating | <i>Rt / Lf / Mixed</i> | | _____ |

Please describe daily physical activity:

Types of activity? _____
How long at a time? _____
How many days per week? _____

Please describe client's sleeping habits:

Nighttime from _____ to _____ Quality of sleep: _____
Naps from _____ to _____ Quality of sleep: _____
Does the client have dreams, nightmares or night terrors? Yes/No *If yes, Please explain* _____

Goals and Objectives

What are your specific goals and objectives working with Liberty4Kids? *(Academic, behavioral, emotional...)*

Daily amount of time parents can implement program activities? _____

Daily amount of time others can assist? *(mother's helpers, teachers, sibling, grandparents)* _____

Liberty Consultants is an organization founded to assist parents in helping their children reach their God-given potential. Information is made available as research confirms its validity. Program recommendations are not medical, therapeutic or psychological prescriptions. Activities are recommended for education and review by the parents. Implementation of these activities is at the sole discretion of the family. Candace Boyle is an educator, not a licensed medical professional. If medical services are needed, the family is urged to consult with the appropriate medical professional.

I acknowledge that I have read and completed this application in full. To the best of my knowledge, all the information is accurate and true. I understand that Liberty and those affiliated with Liberty are not assuming liability for the client. I, as the parent, guardian or client, assume complete responsibility.

Signature _____ Relationship _____ Date _____

Signature _____ Relationship _____ Date _____