# Liberty Consultants

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Please attach recent photo of client

# APPLICATION FORM – ADULT

Client's Name _____ Today's Date _____
Address _____ Date of birth _____
_____ Home Phone _____
City _____ Work Phone _____
State _____ Zip _____ Fax _____
Email: _____
Was client adopted? _____ If yes, at what age? _____
Occupation: _____ from where? _____

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

Have you listened to the Brain Power ~ Tap Into It tapes? Yes / No Spouse? Yes / No
How did you become aware of Liberty Consultants? _____

## Family Information:

Child's Name _____ Date of Birth _____ On program? Yes ❑ No ❑
Child's Name _____ Date of Birth _____ On program? Yes ❑ No ❑
Child's Name _____ Date of Birth _____ On program? Yes ❑ No ❑
Child's Name _____ Date of Birth _____ On program? Yes ❑ No ❑
Child's Name _____ Date of Birth _____ On program? Yes ❑ No ❑

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Office Code _____

## 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:

| *Date* | *Examination* | *Physician* | *Recommendations* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Does the client have history of:

- Congestion and/or sinus infections? Yes/No
- Colds? 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.* _____

_____

## JOB RELATED ABILITIES

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

- Visualization
- Conceptualization
- LongTerm Memory
- Short Term Memory
- Other (explain)_____

List specific skills needed to perform your job._____

_____

_____

_____

## 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
- Farsighted
- Astigmatism
- Glaucoma
- Hyperperipheral
- Macular problems
- Light sensitivity
- Color blindness
- Cortical Blindness
- Amblyopia
- Strabismus
- Other: _____
- Nystagmus
- Cataracts

Does the client enjoy watching TV? Yes/No

Does the client enjoy computer? Yes/No

Does the client enjoy reading? Yes/No

Does the client enjoy listening to books on tape? 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 the client *(i.e. 2 years 3 months):*

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

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

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

Please list educational, developmental or psychological testing or diagnosis:

| *Date* | *Educ./Dev. Examination* | *Administered by* | *Recommendations* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## Educational History

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

_____

_____

_____

List any education problems, labels, classifications or educational diagnoses. *(Past or current)*_____

_____

_____

Does the client struggle with the following academic skills:

- Reading ability Yes/No/Not sure
- Letter reversals Yes/No/Not sure
- Logic problems Yes/No/Not sure
- Math computation Yes/No/Not sure
- Math concepts 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 | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Meat | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Fresh fruit | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Vegetables (Cooked) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Vegetables1 (Raw) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Sugar | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Sweeteners / Preservatives | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| White flour | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Artificial color/flavor | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Alcohol | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Tobacco | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

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.* _____

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

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

How often has the client been on antibiotics? _____

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

# Therapy History

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

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

# Accomplishments

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

_____

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)*

- Balance
- Coordination
- Crawling
- Creeping
- Muscle tone low/high
- Running
- Walking
- Weakness
- Other:

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

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

Please describe daily physical activity:

Types of activity?_____

Amount of time/days per week? _____

Please describe client's sleeping habits:

Night 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 Liberty Consultants?

Professionally: _____

_____

Academically: _____

_____

Personally: _____

_____

Who will assist you in implementing the program? _____

Daily length of time program will be implemented_____

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 information is accurate and true. I understand that Liberty and those affiliated with Liberty are not assuming liability for the client. I, as the client, assume full responsibility.

Signature _____ Relationship_____ Date _____

Signature _____ Relationship_____ Date _____