Application — Learning Dynamics, LLC

Name of person assessed: *Last, First ,MI*_____ **Date of Birth:**_____

Address_____**City**_____**State**_____**Zip**_____

Mother's: *Last, First ,MI*_____ **Phone:** Cell (_____)_____Other (_____)_____

Father's: *Last, First ,MI*_____ **Phone:** Cell (_____)_____Other (_____)_____

Guardian's: *Last, First ,MI*_____ **Phone:** Cell (_____)_____Other (_____)_____

Guardian's Relationship to Student:_____ **Primary Email for Contact:**_____

Occupation: Mother_____Father_____Guardian_____

Siblings: *Names/Ages*_____

Student's school name or if an adult, list occupation:_____

How/from whom did you hear about Learning Dynamics?_____

General Information

Give a brief statement of the primary reason for today's assessment:_____

_____

Indicate and diagnosis/labels/disorders that have been used to describe this person: ❍ ADD ❍ ADHD ❍ Dyslexia/Reading problem ❍ Learning Disability ❍ Autistic/Asperger's/PDD ❍ Speech/Language Disability ❍ Physical Disability ❍ Auditory Processing ❍ Other _____

List any other specialists you have been to for testing or therapy:_____

_____

****Please attach copies of relevant test results: Formal educational testing such as IQ, report cards or informal classroom assessements.**

Academic History

Indicate any probelms in the following areas:

❍ Reading ❍ Comprehension ❍ Reversals of letters or words ❍ Motivation/behavior ❍ Avoidance of school work ❍ Overly Active
❍ Writing ❍ Low Self-Esteem ❍ Loses Place/skips lines ❍ Attention/Concentration ❍ Works too hard on school work
❍ Math ❍ Spelling ❍ Poor Memory ❍ Slow work ❍ Other_____

Is the student achieving at expected levels in school? ❍ Yes ❍ No Comments:_____

_____

School:_____**Type of classroom:** ❍ Mainstream-all subjects ❍ Special classroom-all subjects ❍ Special classroom-some subjects

Grade: _____**Has the student ever repeated a grade:** ❍ Yes ❍ No Comments: _____

Medical History

Birth: ❍ Premature ❍ Late ❍ Normal Birth weight:_____ **Complications during pregnancy or delivery?** ❍ Yes ❍ No Comments:_____

Current height:_____ **Current weight:**_____ **Indicate problem areas:** ❍ Headaches ❍ Vision ❍ Speech or hearing ❍ Other _____

List all major health problems to date:_____

_____

List current medications:_____

Allergies:_____

Financial Need

Number of dependents in home:_____**List names and ages:**_____

_____

Household income: Attach copy of income tax return with SSN blocked out / Copy of eligibility form for school lunch program or other income assistance.