PERSONAL HISTORY *(Please circle when necessary)*

First name_____ Last name_____ Profession_____

Address_____ City_____ State_____ Postcode _____

Country_____ Home Phone_____ Mobile Phone_____

Work Phone_____ E-mail_____

REASON FOR CONSULTATION

Please describe as precisely as possible the reasons why you want to be assessed:

_____
_____
_____
_____
_____

Please describe the issue(s) background (When, how, why did it start):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please describe in which situations these above difficulties occur?

_____
_____
_____
_____
_____

MEDICAL HISTORY *(Please circle when necessary)*

Have you been diagnosed with any medical conditions? Please specify?

_____
_____
_____
_____
_____

Have you received any other interventions or therapies? Yes /No

If so, please specify which ones and when

_____

Have you been diagnosed with a visual impairment? Yes/No

Do you wear glasses? Yes/No

Have you been diagnosed with an auditory impairment? Yes/No

Which is your dominant hand? Right Left Both

Are you sensitive to fabrics/ textures? Yes/No

Tags in clothing? Yes/No

Are you overly sensitive in general? Yes/No

Medications *(please include over the counter medications, herbal products, supplements and vitamins)*

Have you been involved in any accidents? Yes/No

If yes please specify

Have you ever been hospitalized? Yes/No

If yes, please explain

Please list all the therapists/ specialists you have visited;

Have you had any of the following procedures?

ECG (electrocardiogram) EEG (electroencephalogram) MRI (magnetic resonance imaging)

Other:

Do you have a diagnosed seizure disorder? Yes/No

When was it diagnosed?

_____
_____
_____

At what age did the first seizure start? _____

How often do you have seizures? _____

ENT HISTORY *(Please circle when necessary)*

Do you do any of the following;

Snore	Breath loudly while asleep
Breathe loudly at rest	Keep mouth open often
Breathe loudly during activity	Tend to stick out tongue

Are you prone to any of the following;

Colds	Ear infections
Bronchitis	Pneumonia
Upper respiratory infections	Thrush

If so, how often?

_____
_____
_____
_____
_____

Have you had any problems with tonsils or adenoids? Yes/No

If yes, please explain

_____
_____
_____
_____

Do you present with any of the following conditions (circle all that apply)?

Earaches	Tinnitus (ringing in ears)
Ear discharge	Hearing loss

Sinus trouble	Facial pain/ Pressure
Nasal congestion/runny nose	Sore throat
Nose bleeds	Voice hoarseness/croakiness
Sleep apnea	Dysphagia (trouble swallowing)

Are you overly sensitive to loud sounds or noises? Yes/No

Do you hear sounds others don't, or before others notice? Yes/No

Are you able to pay attention in a noisy environment? Yes/No

Do you frequently ask people to repeat what they say? Yes/No

Do you find that you "tune out" or ignore sounds from the environment? Yes/No

ALLERGIES/SENSITIVITES *(Please circle when necessary)*

Do you suffer from food or environmental allergies or sensitivities? Yes/No

Have you ever been tested for allergies? Yes/No

If yes, please specify the types of test and results

_____
_____
_____
_____

Have you ever suffered from eczema? Yes/No

Asthma? Yes/No

If yes, please specify since when?

_____
_____
_____

Other rashes? Yes/No

Yeast infections? Yes/No

Do you suffer from gut issues? Yes/No

If yes, please specify

_____
_____
_____

Does anyone in your family suffer from any allergies or food intolerances? Yes/No

If yes, please specify the relationship to you and what are they allergic or sensitive to:

SLEEPING HISTORY *(Please circle when necessary)*

What time do you wake up? _____

What kind of mood when waking? _____

What time do you go to bed at night? _____

Do you have difficulties with falling asleep? Yes/No

Do you sleep through the night? Yes/No

Do you wake at night? Yes/No

If yes, what time? _____

GOALS

What results would you like to achieve with the Tomatis® listening program?

Eg: better auditory processing.

Dr Donna Palmer
BSc MCh Tomatis® Level 4 Consultant
Practicing MSL Educational Specialist (IMSLE, Aus)
Accredited Member of the Australian Dyslexia Association
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