THERAPEUTIC LISTENING PROGRAM FOLLOW UP

CLIENT NAME: _____ Date: _____

Form Completed By: _____

1. Current CD:_____
2. Client listens _____/mins_____x/day
3. How has the child responded to the program? Please describe any changes in …
   - Emotional tone (i.e. more excited, more irritable, more animated, affect)

   - Arousal (i.e. energy level, sleep/wake patterns, hunger/thirst, bowel/bladder, transitions,

   - Motor skill (i.e. activity participation, gross motor coordination, timing/sequencing)

   - Social Behavior (i.e. language, interactions with peers/family, awareness of self/self-esteem)

4. Anything else?

Therapist Name: _____

Contact info: _____

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