****

**GENERAL INFORMATION:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_ Gender: \_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status of parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fathers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF SIBLINGS: | AGE | NAME | AGE |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list anyone else that lives in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your primary concerns for your child’s **Occupational Therapy** **Services:**

**\_\_\_\_\_ Handwriting \_\_\_\_\_ Sensory Processing \_\_\_\_\_ Letter Reversals**

**\_\_\_\_\_ Fine Motor \_\_\_\_\_ Coordination \_\_\_\_\_ Safety Awareness**

**\_\_\_\_\_ Self Care \_\_\_\_\_ Pick Eater \_\_\_\_\_ Right/Left Awareness**

**Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**What are your primary concerns for your child’s **Speech Therapy** services:

**\_\_\_\_\_ Conversation \_\_\_\_\_ Answering Questions \_\_\_\_\_ Listening/Memory**

**\_\_\_\_\_ Sentence Structure \_\_\_\_\_ Social/Emotional \_\_\_\_\_ Articulation**

**\_\_\_\_\_ Reading /Writing \_\_\_\_\_ Stuttering \_\_\_\_\_ Problem Solving**

**Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BEHAVIOR**

Check any of the following that describes child’s behavior

**\_\_\_\_\_ Shy \_\_\_\_\_ Anxieties \_\_\_\_\_ Over Active**

**\_\_\_\_\_ Short Attention \_\_\_\_\_ Slow Learner \_\_\_\_\_ Withdrawn**

**\_\_\_\_\_ Temper Tantrums \_\_\_\_\_ Suck Thumb \_\_\_\_\_ Prefers to Play Alone**

**MEDICAL HISTORY:**

Does your child have a current diagnosis (es): \_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Diagnosis** | **Age when diagnosed** | **Physician** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please list current medications and dosage information:**

|  |  |  |
| --- | --- | --- |
| **Medication/Dosage** | **Start date** | **Treatment For** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Has your child’s **Hearing** been evaluated? **YES / NO**

Who did the testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was the testing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were there any concerns from testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child’s **Vision** been evaluated? **YES / NO**

Who did the testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was the testing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were there any concerns from testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child care an EpiPen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major illness and/or surgeries and date**

**\_\_\_\_\_Chronic Ear Infections \_\_\_\_\_ Tubes \_\_\_\_\_ Seizures**

**\_\_\_\_\_ Surgery \_\_\_\_\_ Broken Bones \_\_\_\_\_ Tonsillectomy**

**\_\_\_\_\_ Hospitalized \_\_\_\_\_ Cancer \_\_\_\_\_ Other**

**Please describe with dates of illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EDUCATIONAL INFORMATION:**

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Have teachers specified any areas of difficulty? Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently receiving services through the school system? \_\_\_\_\_\_\_\_\_

If yes, please list specific services and duration/frequency

|  |  |
| --- | --- |
| **Service** | **Duration and Frequency** |
|  |  |
|  |  |
|  |  |

Has your child received prior services outside of the school system? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check those that apply and list previous locations and dates of past or current services:

\_\_\_ Speech Therapy \_\_\_Occupational Therapy \_\_\_ Physical Therapy

\_\_\_Educational Services \_\_\_ Behavioral Therapy \_\_\_ Vision Therapy

**PRENATAL AND BIRTH HISTORY:**

Place of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any complications during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any complications during delivery/labor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was NICU stay required? If yes, please list length of time and for what reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If premature, how many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child adopted? \_\_\_\_Yes \_\_\_\_ No How old was your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history or any relevant medical/behavioral issues in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your child’s strengths? \_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your child’s favorite activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child interact with:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Above Average** | **Average** | **Poor** | **Very Poor** |
| **Siblings** |  |  |  |  |
| **Parents** |  |  |  |  |
| **Peers** |  |  |  |  |
| **Teachers** |  |  |  |  |

Place a check in the appropriate boxes for the following statements:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Always | Often | Sometimes | Never | Don't Know |
| Is angry or irritable |  |  |  |  |  |
| Has strong fears |  |  |  |  |  |
| Gets easily discouraged |  |  |  |  |  |
| Becomes sad or tearful |  |  |  |  |  |
| Finds transitions stressful |  |  |  |  |  |
| Prefers to be in charge |  |  |  |  |  |
| Has temper tantrums |  |  |  |  |  |
| Finds new tasks stressful |  |  |  |  |  |

**Speech & Language**:

Please indicate your child’s ability in each category:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very Poor** | **Poor** | **Average** | **Above Average** | **Does not Apply** |
| Expresses wants and needs |  |  |  |  |  |
| Participates in 4-6 turn conversation |  |  |  |  |  |
| Answers questions about past events |  |  |  |  |  |
| Verbally expresses their emotions |  |  |  |  |  |
| Utilizes language when distressed |  |  |  |  |  |
| Age appropriate vocabulary |  |  |  |  |  |
| Answers why questions |  |  |  |  |  |
| Answers how questions |  |  |  |  |  |
| Retells a simple story |  |  |  |  |  |
| Attention span |  |  |  |  |  |
| Follows a 2 step direction |  |  |  |  |  |
| Ability to organize personal items |  |  |  |  |  |
| Ability to play with peers |  |  |  |  |  |
| Ability to understand other person’s perspective |  |  |  |  |  |
| Stays engaged with peers |  |  |  |  |  |
| Intelligibility of speech |  |  |  |  |  |

**DEVELOPMENTAL HISTORY:**

Please list the approximate age when your child:

Rolled over: \_\_\_\_\_\_ Sat unsupported: \_\_\_\_\_\_ Crawled: \_\_\_\_\_\_ Walked : \_\_\_\_\_\_\_

Toilet trained: Bladder: Day \_\_\_\_\_\_ Night\_\_\_\_\_\_ Bowel: Day\_\_\_\_\_\_ Night: \_\_\_\_\_\_

Babbled: \_\_\_\_\_\_\_\_\_\_\_\_ First Words: \_\_\_\_\_\_\_\_\_\_\_\_ Sentences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer YES or NO or N/A to the following questions about your child:**

**Feeding/Oral Motor:**

Drinks from a cup \_\_\_\_\_\_Uses the following utensils: Spoon\_\_\_\_\_ Fork\_\_\_\_ Knife\_\_\_\_\_

Favors certain foods/textures? If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on a special diet? If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Demonstrate frequent drooling: \_\_\_\_\_\_ Uses pacifier or suck their thumb: \_\_\_\_\_\_\_\_\_\_\_\_

Chews non-food objects: \_\_\_\_\_\_\_\_\_\_ Difficulty chewing or swallowing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dressing:**

Dresses self: Shirt\_\_\_\_\_ Pants\_\_\_\_ Underwear \_\_\_\_\_ Buttons\_\_\_\_\_\_ Zippers \_\_\_\_\_\_

Undresses self: Shirt\_\_\_\_\_ Pants\_\_\_\_ Underwear \_\_\_\_\_ Buttons\_\_\_\_\_\_ Zippers \_\_\_\_\_\_

Tie shoes: \_\_\_\_\_\_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grooming:**

Brush teeth: \_\_\_\_\_\_\_ Wash face: \_\_\_\_\_\_\_\_ Wash hands: \_\_\_\_\_\_\_ Brush hair: \_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bathing:**

Turn on/off water: \_\_\_\_\_\_\_\_ Wash hair: \_\_\_\_\_\_\_\_\_\_ Wash body: \_\_\_\_\_\_\_\_\_\_\_

Rinse self: \_\_\_\_\_\_\_\_\_ Dry body: \_\_\_\_\_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Toileting:**

Manage clothing: \_\_\_\_\_\_\_\_ Wipe: \_\_\_\_\_\_\_\_\_\_\_ Sequence steps: \_\_\_\_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleeping:**

Independent: \_\_\_\_\_ All night: \_\_\_\_\_\_ In their own bed: \_\_\_\_\_\_Night Terrors: \_\_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Handwriting/Fine Motor:** Please answer YES or NO or N/A to the following questions about your child:

Dominant/preferred hand: \_\_\_\_\_\_\_\_\_\_ Write alphabet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reverse letters/numbers: \_\_\_\_\_\_\_ Difficulties with sizing/spatial organization: \_\_\_\_\_\_\_\_\_

Is this an area of concern for you? If yes, please list details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gross Motor Skills:**

Catch a ball: \_\_\_\_\_\_\_\_\_\_ Throw a ball: \_\_\_\_\_\_\_\_\_\_ Kick a ball: \_\_\_\_\_\_\_\_\_\_

Ride a bicycle: \_\_\_\_\_\_\_\_ Jump rope: \_\_\_\_\_\_\_\_\_\_ Move slowly: \_\_\_\_\_\_\_\_\_\_

Seems uncoordinated: \_\_\_\_\_\_\_\_\_\_

**ADDITIONAL COMMENTS:**

Please list any additional comments that you feel will help us better understand your child. (Coping methods, sensory strategies, communication needs, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Thank you for taking the time to complete these forms so that we might better serve your child.*