



DEVELOPMENTAL HISTORY *Ages 4-14 years*

Child's Name:	_____	_____
	first	last

	nickname	
Birth Date:	_____	Age: _____ M / F
Child's School:	_____	Current Grade: _____
Teacher(s):	_____	Type of Class: Typical/Integrated/Separate
Pediatrician:	_____	Classroom Assistance (if any): _____
Parent One:	_____	Profession: _____
Address:	_____ _____	
Home Phone:	_____	Cell Phone: _____
Parent Two:	_____	Profession: _____
Address (If different than above):	_____ _____	
Home Phone:	_____	Cell Phone: _____
Marital Status:	Married Single Divorced	Other: _____

Dear Parent or Guardian,
Please share with us what you hope to gain from this evaluation, therapy, or consultation:

Signature of Person(s) Completing Form: _____
Relationship to Client: _____

DEVELOPMENTAL HISTORY *Ages 4-14 years*

Thank you for taking the time to fill out this history. The valuable information you share about your child's accomplishments, struggles, and the goals you hope they will achieve assists us in developing a comprehensive assessment and intervention plan.

MEDICAL HISTORY

Please indicate if your child has or has had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Birth Weight | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Low Birth Weight | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Viral Infections | <input type="checkbox"/> Visual or Ocular-Motor Problems | <input type="checkbox"/> Cognitive Delays |
| <input type="checkbox"/> Strep Infections | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Non-Verbal Learning Disability | <input type="checkbox"/> Congenital Anomalies |
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Other Learning Disabilities | <input type="checkbox"/> Fragile X Syndrome |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Gastrointestinal Issues | <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Mitochondrial Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Obsessive-Compulsive Disorder | <input type="checkbox"/> Braces/Assistive Devices |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety or Mood Disorder | <input type="checkbox"/> Other: |

Please describe any medical precautions, physical limitations, or relevant information about your child's medical history that may help us better understand how to work with your child. (i.e. allergies, seizure protocol, inhaler, dietary restrictions)

Does your child currently take any medications or supplements (e.g. melatonin, fish oil)?

Med: _____	Frequency: _____	Purpose: _____
Med: _____	Frequency: _____	Purpose: _____
Med: _____	Frequency: _____	Purpose: _____
Supplement: _____	Frequency: _____	Purpose: _____
Supplement: _____	Frequency: _____	Purpose: _____

PREVIOUS TESTING

Please list professionals that have done evaluations (E) and/or treatment (T) with your child and circle the letter for the type of service they provided (e.g. EI, PT, OT, Speech, Developmental Pediatrician, Nutritionist, Eye Doctor):

Name: _____	Prof: _____	E / T
Name: _____	Prof: _____	E / T
Name: _____	Prof: _____	E / T
Name: _____	Prof: _____	E / T
Name: _____	Prof: _____	E / T

BIRTH HISTORY

Is your child adopted? No Yes
If Yes, please specify the birth country: _____ Age adopted: _____
Is the child with you in foster care? No Yes
Is your child part of a multiple pregnancy? No Yes: Twins Triplets Other: _____

Did the mother have any of the following difficulties during pregnancy?

- | | | |
|--|---|---|
| <input type="checkbox"/> Infections | <input type="checkbox"/> Spotting/ Bleeding | <input type="checkbox"/> Prolonged Labor |
| <input type="checkbox"/> Significant Illness | <input type="checkbox"/> Shocks or Unusual Stresses | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Premature Labor | <input type="checkbox"/> Mandatory Bed Rest |

Please elaborate on the complications during pregnancy (e.g. medications needed, complications during labor and delivery):

Birth Weight: _____ Apgar Scores: _____

Did the baby have any of the following complications during and after delivery?

- | | | |
|---|--|---|
| <input type="checkbox"/> Premature (# of Wks) _____ | <input type="checkbox"/> Meconium Aspiration | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Breech | <input type="checkbox"/> Forceps Delivery | <input type="checkbox"/> Apnea |
| <input type="checkbox"/> Cord Wrap | <input type="checkbox"/> Suction Delivery | <input type="checkbox"/> Birth Injuries |
| <input type="checkbox"/> Fetal Distress | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Other: _____ |

Please elaborate on these difficulties and how they were resolved (e.g. medications, procedures, ICU):

DEVELOPMENT

As a baby did your child experience any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty w/ breast feeding | <input type="checkbox"/> Not calmed by cuddling | <input type="checkbox"/> Startled when approached |
| <input type="checkbox"/> Difficulty w/ bottle feeding | <input type="checkbox"/> Trouble settling to sleep | <input type="checkbox"/> Strong startle with noises |
| <input type="checkbox"/> Difficulty w/ baby food | <input type="checkbox"/> Resistance to lying on belly | <input type="checkbox"/> Cried when lifted in the air |
| <input type="checkbox"/> Difficulty eating soft solids | <input type="checkbox"/> Difficulty engaging socially | <input type="checkbox"/> Cried w/ head tipped back |
| <input type="checkbox"/> Colic (# of Mths) _____ | <input type="checkbox"/> Inconsolable crying | <input type="checkbox"/> Other: _____ |

Please comment on any past stressful events: _____

As well as you can remember, please tell us when your child achieved the following developmental milestones:
(Leave it **blank** if you are unsure, put **N/A** if they are not yet achieved, or **X** if they did not occur):

Smiled _____	Walked Independently _____	Fell Asleep Alone _____
Sat Alone _____	Said First Words _____	Slept Through Night _____
Rolled Over _____	Combined Words _____	Toilet for Urine _____
Crawled _____	Spoke Sentences _____	Toilet for BM _____

Please comment on any concerns you have about your child's development: _____

Please tell us about your child's gifts and strengths: _____

SPEECH AND LANGUAGE HISTORY

Please indicate all means of communication currently used by your child:

- | | | |
|--|---|--|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Gestures | <input type="checkbox"/> Taking person to desired item |
| <input type="checkbox"/> Pointing | <input type="checkbox"/> Facial Expressions | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Vocalizations | <input type="checkbox"/> Augmentative Device (pictures, high tech system, etc.) | |

How often does your child use speech? Always Frequently Sometimes Rarely Never

How does your child primarily make his/her needs known? _____

How well is your child understood by familiar listeners (parents, siblings, friends)? _____

How well is your child understood by unfamiliar listeners? _____

How do you currently try to help your child with his/her communication skills? Are you currently using any pictures or signs within the home or school environment? _____

Does your child have trouble initiating and maintaining eye contact? No Yes

Is your child aware of his/her communication difficulties? No Yes

Does your child have difficulty attending or responding when spoken to? No Yes

Do you find yourself frequently repeating what you've said or directions you've given? No Yes

Do you have concerns with your child's short-term memory skills? No Yes

Does your child have difficulty responding to WH questions (who, what, where, etc.)? No Yes

Does your child have a hard time asking questions? No Yes

Do you have difficulty following a story that your child is telling? No Yes

Do they omit relevant details when telling a story? No Yes

Does your child exhibit signs of word retrieval difficulty (uses words wrong, labels things as 'this' or 'that' rather than using the word, frequently says 'uh' or 'um')? No Yes

Does your child have difficulty initiating play with other children? No Yes

Does your child struggle to take turns within play/conversation with others? No Yes

Does your child have trouble understanding or picking up on nonverbal language (e.g. body language, facial expression, tone of voice)? No Yes

Does your child have a decreased interest in playing/interacting with peers? No Yes

Do you have any concerns with your child's behaviors that may be related to his or her speech and language difficulties? No Yes

Does your child show signs of frustration during times of communication breakdown? No Yes

If you answered yes to any of the above questions, please describe: _____

What level of direction can your child follow? (check all that apply) One Step Multiple Steps Routine Unfamiliar

Please provide any further information that would help us understand your child and his/her present communication abilities: _____

ACTIVITIES OF DAILY LIVING

SLEEP SKILLS

Where does your child sleep? _____

Does your child take naps? No Yes

If yes, please answer: Frequency of naps: _____ Duration of naps: _____

Please describe any specific details regarding naptime and bedtime routines: _____

What activities are a part of your child's bedtime routine? (Check all that apply)

- | | | |
|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Bath time | <input type="checkbox"/> Singing/humming | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Bouncing | <input type="checkbox"/> Massage | <input type="checkbox"/> Rocking |
| <input type="checkbox"/> Holding | <input type="checkbox"/> Comfort items | <input type="checkbox"/> Other: _____ |

Does your child have difficulty:

- | | | |
|--|---|--|
| <input type="checkbox"/> Falling asleep | <input type="checkbox"/> Staying asleep | <input type="checkbox"/> Night terrors |
| <input type="checkbox"/> Frequent night waking | <input type="checkbox"/> Other: _____ | |

How many times per night does he/she wake?

- | | | |
|---------------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> Almost never | <input type="checkbox"/> 1-3 | <input type="checkbox"/> 4-5 |
|---------------------------------------|------------------------------|------------------------------|

What does your child do when he/she awakens?

- | | | |
|--|--|---|
| <input type="checkbox"/> Whimper | <input type="checkbox"/> Puts self back to sleep | <input type="checkbox"/> Scream |
| <input type="checkbox"/> Plays with toys | <input type="checkbox"/> Calls for parent | <input type="checkbox"/> Goes to parents' bedroom |
| <input type="checkbox"/> Other: _____ | | |

What activities do you use to get your child back to sleep?

- | | | |
|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> Feeding | <input type="checkbox"/> Singing/humming | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Holding | <input type="checkbox"/> Bouncing | <input type="checkbox"/> Rocking |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Other: _____ | |

TOILETING

Does your child experience urinary/bowel issues or difficulty? No Yes

If yes, please specify and indicate frequency each occurs:

- | | | |
|---|--|--|
| <input type="checkbox"/> Constipation: _____ | <input type="checkbox"/> Loose stools: _____ | <input type="checkbox"/> Bedwetting: _____ |
| <input type="checkbox"/> Lack of awareness: _____ | <input type="checkbox"/> Incontinence during the day | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Bowel: _____ | |
| | <input type="checkbox"/> Bladder: _____ | |

Does your child have difficulty-wiping self after toileting? No Yes

What routines are helpful for getting your child to participate in toileting? _____

FEEDING SKILLS

Is there a disruption in family mealtime as a result of your child's eating patterns?

No Yes

If yes, please comment: _____

Does your child refuse to eat, spit out, or gag on foods?

No Yes

If yes, based on which characteristics:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Temperature | <input type="checkbox"/> Smells | <input type="checkbox"/> Crunchy foods |
| <input type="checkbox"/> Chewy foods | <input type="checkbox"/> Mixed food textures | <input type="checkbox"/> Food texture |
| <input type="checkbox"/> Food color | <input type="checkbox"/> Other: | |

Does your child exhibit any oral behaviors?

No Yes

If yes, check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Examines objects by placing in mouth | <input type="checkbox"/> Grinds teeth |
| <input type="checkbox"/> Pocket food/stuffs food, drool, very messy eater | <input type="checkbox"/> Gags/vomits frequently |
| <input type="checkbox"/> Bites/chews objects/clothing frequently | <input type="checkbox"/> Very messy eater |
| <input type="checkbox"/> Examines objects through smell | <input type="checkbox"/> Excessive drooling |

Does your child have difficulty sitting during meals?

No Yes

My child can sit for:

- | | | |
|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> 1-2 minutes | <input type="checkbox"/> 3-5 minutes | <input type="checkbox"/> 6-10 minutes |
| <input type="checkbox"/> Entire meal | | |

Does your child: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Feed self with spoon | <input type="checkbox"/> Feed self with fork | <input type="checkbox"/> Cut food with a knife |
| <input type="checkbox"/> Drink with a cup | <input type="checkbox"/> Open snack and juice boxes | <input type="checkbox"/> Drink through a straw |

Does your child have any medical issues related to feeding?

No Yes

If yes, please comment: _____

What routines are helpful for getting your child to participate in mealtime or feeding activities? _____

GROOMING

Does your child dislike or resist grooming activities?

No Yes

If yes (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Tooth brushing | <input type="checkbox"/> Hair brushing/combing | <input type="checkbox"/> Bathing |
| <input type="checkbox"/> Blowing nose | <input type="checkbox"/> Face washing | <input type="checkbox"/> Haircuts |
| <input type="checkbox"/> Hair washing | <input type="checkbox"/> Nail trimming | <input type="checkbox"/> Other(s): _____ |

Does your child avoid or fear grooming devices?

No Yes

If yes (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Electric toothbrushes | <input type="checkbox"/> Barber's clippers | <input type="checkbox"/> Dentistry tools |
| <input type="checkbox"/> Other(s): | | |

Does your child avoid or fear the sounds associated with grooming activities:

No Yes

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Bath water | <input type="checkbox"/> Hair dryer | <input type="checkbox"/> Hand dryer |
| <input type="checkbox"/> Toilet flushing | <input type="checkbox"/> Other(s): _____ | |

DRESSING

Which clothing is your child able to **Take Off** independently?

- Underwear
 Shoes

- Pants
 Socks

- Shirt
 Coat

Which clothing is your child able to **Put On** independently?

- Underwear
 Shoes

- Pants
 Socks

- Shirt
 Coat

Which fasteners can your child manage independently?

- Snaps
 Tie shoes

- Zippers

- Buttons

Was it a struggle learning to tie shoes?

- No Yes

Does your child tend to put clothes on backwards or inside out?

- No Yes

Does your child have difficulty with trying on or wearing new clothes?

- No Yes

Does your child struggle with clothing changes for cold/warm seasons (e.g. switching from long to short sleeves?)

- No Yes

Does your child frequently adjust clothing, as if uncomfortable?

- No Yes

Do tags in clothing or seams in socks bother your child?

- No Yes

Is your child selective in the types of clothing he/she will wear (e.g. hats, mittens, jeans, button shirts, layered clothes)?

- No Yes

If you answered yes to any of the above questions, please describe the reaction or behavior seen: _____

What types of clothing or textures are preferred _____

What types of clothing or textures are avoided? _____

What routines and/or assistance are helpful for getting your child to participate in dressing activities (please indicate how much assistance and prompting are needed for success)? _____

SOCIAL PARTICIPATION/FAMILY LIVING/BEHAVIORAL RESPONSES

Are you limited in attending family/social gatherings because of your child's behavior or reactivity to events? No Yes

Does your child struggle with transitions? No Yes

Does your child have comfort items that help him/her transition or engage in social situations? No Yes

Does your child have difficulty tolerating social touch or hugs from others? No Yes

If you answered yes to any of the above questions, please describe the reaction or behavior seen: _____

Does your child have a hard time dealing with people's voices? No Yes

If yes, check all that apply:

Loud or raised voices

Singing

Men's voices

Women's voices

Children's voices

Screaming

Cheering

Crying

Does your child exhibit aggressive behavior? No Yes

If yes: Is it directed toward him/herself? No Yes

If yes: Is it directed toward others? No Yes

What types of behaviors are exhibited? (Check all that apply)

Biting

Kicking

Pinching

Hitting

Spitting

Other:

Does your child exhibit meltdowns and/or tantrums? No Yes

If yes: How frequently do they occur? _____ times/day OR _____ times/week

On average, how long does a meltdown/tantrum last? _____

Are tantrums a source of distress to other family members? No Yes

What triggers the meltdowns/tantrums? _____

Describe the strategies that are effective for helping calm your child during and after a meltdown/tantrum _____

Does your child exhibit repetitive behaviors?

No Yes

If yes: which behaviors are demonstrated? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Hand Flapping | <input type="checkbox"/> Breath holding | <input type="checkbox"/> Self-talk |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Rocking |
| <input type="checkbox"/> Spinning self | <input type="checkbox"/> Spinning objects | <input type="checkbox"/> Biting |
| <input type="checkbox"/> Humming | <input type="checkbox"/> Visual fixing | <input type="checkbox"/> Jumping |
| <input type="checkbox"/> Mouthing objects | <input type="checkbox"/> Smelling | <input type="checkbox"/> Other(s) (please describe): |

What routines are helpful for getting your child to participate in social situations? _____

PLAY SKILLS/PEER INTERACTION

How long can your child play alone?

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Less than 2 mins | <input type="checkbox"/> 2-5 mins | <input type="checkbox"/> 5-10 mins |
| <input type="checkbox"/> 10-30 mins | <input type="checkbox"/> more than 30 mins | |

Does your child have difficulty conceiving play ideas and/or organizing a plan to direct play?

No Yes

Does your child have difficulty with imaginative play?

No Yes

Which playground equipment will your child **play on**? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Swings | <input type="checkbox"/> Monkey bars | <input type="checkbox"/> Slide |
| <input type="checkbox"/> Ladders | <input type="checkbox"/> Climbing wall | <input type="checkbox"/> Bridges |
| <input type="checkbox"/> Vertical climbers | <input type="checkbox"/> Merry-go-round | <input type="checkbox"/> Spring riders |
| <input type="checkbox"/> Crawl tunnels | <input type="checkbox"/> Teeter Totter | <input type="checkbox"/> Other(s): |

Which playground equipment will your child **avoid**? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Swings | <input type="checkbox"/> Monkey bars | <input type="checkbox"/> Slide |
| <input type="checkbox"/> Ladders | <input type="checkbox"/> Climbing wall | <input type="checkbox"/> Bridges |
| <input type="checkbox"/> Vertical climbers | <input type="checkbox"/> Merry-go-round | <input type="checkbox"/> Spring riders |
| <input type="checkbox"/> Crawl tunnels | <input type="checkbox"/> Teeter Totter | <input type="checkbox"/> Other(s): |

Please indicate the following skills your child can do:

- | | | |
|---|--|---|
| <input type="checkbox"/> Kick a ball | <input type="checkbox"/> Pump a swing | <input type="checkbox"/> Ride a bike with training wheels |
| <input type="checkbox"/> Throw a ball with accuracy | <input type="checkbox"/> Ride a scooter | <input type="checkbox"/> Ride a bike without training wheels |
| <input type="checkbox"/> Catch a ball | <input type="checkbox"/> Ride a tricycle | <input type="checkbox"/> Alternate feet going up and coming down stairs |

Was it a struggle for your child to learn any of the skills listed above?

No Yes

If yes can you please comment on what was challenging and any strategies that you have found assist your child to learn new motor skills: _____

Please check any of the following items that pertain to or describe your child:

- | | |
|--|--|
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Prefers to play with older children/adults |
| <input type="checkbox"/> Seems to lack self confidence | <input type="checkbox"/> Prefers to play with younger children |
| <input type="checkbox"/> Tends to be bossy or pushy | <input type="checkbox"/> Prefers to play alone |
| <input type="checkbox"/> Has trouble getting along with other children | <input type="checkbox"/> Prefers to sit back and let others lead |
| <input type="checkbox"/> Gets easily frustrated | <input type="checkbox"/> Prefers active play |
| <input type="checkbox"/> Can have strong outbursts of anger | <input type="checkbox"/> Prefers sedentary play |
| <input type="checkbox"/> Is more often active and intense | <input type="checkbox"/> Does better one on one |
| <input type="checkbox"/> Tends to be impulsive | <input type="checkbox"/> Has difficulty with large groups |
| <input type="checkbox"/> Poor safety awareness | <input type="checkbox"/> Immature for age |
| <input type="checkbox"/> Tends to be cautious | <input type="checkbox"/> Needs more protection than other children |
| <input type="checkbox"/> Becomes anxious easily | <input type="checkbox"/> Touches people incessantly |
| <input type="checkbox"/> Is more often quiet and withdrawn | <input type="checkbox"/> Has difficulty understanding personal space |
| <input type="checkbox"/> Has difficulty separating from parents | <input type="checkbox"/> Lacks a sense of humor |
| <input type="checkbox"/> Tends to be very set in his/her routines | <input type="checkbox"/> Sensitive to criticism |

MOVEMENT SKILLS

Does your child appear calmer after movement activities? No Yes

Does your child like to be wrapped tightly in a sheet or blanket, or seek tight spaces? No Yes

Does your child shake his/her head vigorously? No Yes

Does your child assume an upside down position frequently? No Yes

Does your child become overly excited after movement activities? No Yes

If you answered yes to any of the above questions, please describe: _____

Is your child preoccupied with seeking intense movement during play? No Yes

If yes, check all that apply

- | | | |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Spinning | <input type="checkbox"/> Bouncing | <input type="checkbox"/> Crashing |
| <input type="checkbox"/> Rocking | <input type="checkbox"/> Jumping | <input type="checkbox"/> Other(s): _____ |

Does your child display any of the following movement difficulties? (Check all that apply) No Yes

- | | |
|---|--|
| <input type="checkbox"/> Avoids age-appropriate gross motor activities | <input type="checkbox"/> Poor coordination or sense of rhythm |
| <input type="checkbox"/> Poor sense of direction or awareness of space | <input type="checkbox"/> Walks on his/her toes |
| <input type="checkbox"/> Seems weaker or tires more easily than peers | <input type="checkbox"/> Fears falling when no real danger exists |
| <input type="checkbox"/> Fearful of being tossed in the air or turned upside down | <input type="checkbox"/> Fearful of heights and/or stairs |
| <input type="checkbox"/> Excessive dizziness from swinging or spinning | <input type="checkbox"/> Avoids activities where feet leave the ground |
| <input type="checkbox"/> Experiences motion sickness in cars, trains, boats, etc. | <input type="checkbox"/> Stamps/slaps feet on ground when walking |
| <input type="checkbox"/> Drags hand on wall or bangs objects when walking | <input type="checkbox"/> Loses balance/trips easily or frequently |
| <input type="checkbox"/> Walks into things or trips over objects on the floor | <input type="checkbox"/> Avoids/fears activities requiring balance |

SCHOOL PERFORMANCE/HOMEWORK

Hand preference: Right Left Not established

What can your child write accurately?

- Name Numbers Address
 Sentence Paragraph

Does your child have difficulty holding tools (pencils, scissors) appropriately? No Yes

Does your child have a hard time cutting with scissors? No Yes

Does your child slump or move in and out of his/her chair while doing work? No Yes

Does your child get overwhelmed when there is a lot of information on a page? No Yes

Does your child demonstrate inefficient ways of doing things (e.g. getting started, organizing work, wasting time, finishing projects on time)? No Yes

If yes, please describe: _____

Please check off any areas that you feel your child is struggling with in school:

- | | | |
|--|--|--|
| <input type="checkbox"/> Sitting still | <input type="checkbox"/> Finishing work | <input type="checkbox"/> Spelling |
| <input type="checkbox"/> Paying attention | <input type="checkbox"/> Social interactions | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Following directions | <input type="checkbox"/> Following the rules | <input type="checkbox"/> Mathematics |
| <input type="checkbox"/> Organizing work | <input type="checkbox"/> Group activities | <input type="checkbox"/> Written tasks |
| <input type="checkbox"/> Working independently | <input type="checkbox"/> Specials (Gym, Music, etc.) | <input type="checkbox"/> Other: |

Please describe the strategies that help your child complete homework _____

What extracurricular activities does your child participate in? _____

Thank you for sharing this information with us!
If you have any additional comments or questions, please feel free to discuss them with your therapist!