Owner
Wendy Jarvis, OTR/L
Office Manager
Brenda Rodriguez

2070 McKenzie St., Suite C
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OT Supervisor
Luke Hill, OTR/L
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Phone: 479.750.7778
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New Patient Pre-Evaluation Packet

***Instructions:** Please complete and return this packet prior to your child's evaluation. Jarvis Pediatric Therapy requires this information for the purpose of completing your child's evaluation with the best information. This packet is required prior to evaluation. Failure to provide these documents may result in incomplete examination or cancelation of evaluation.

If applicable, please also submit:

1. Copy of hearing or vision test results
2. Copy of IEP or 504
3. Previous therapy evaluations
4. Copy of insurance card

Patient Information Form

Date: ______________________________

Child's Name: ____
Last First Middle

Date of Birth: __________________ Email: ____________________________

Primary Language (English, Spanish, etc.):____________________________________

Interpreter Needed? □ Yes □ No

Parent/Guardian: ____
Mother Father

Home Address: ____

____
City State Zip

Home Telephone Number: ______________________Cell: ______________________

Father's Employer: _________________________ Work Phone: __________________

Mother's Employer: _________________________Work Phone: __________________

Primary Care Physician Name: ____

Clinic Name: ____

Telephone: ____

Primary Insurance: _________________________ Policy ID Number: _____________

Subscriber: ____________________ Date of Birth: ___________ SSN:____________

Policy Group Name/Number: ____

Tefra/Medicaid Number: ____

Please have insurance and/or Medicaid cards available at the time of the appointment.

* ALL AREAS MUST BE COMPLETED FOR BILLING PURPOSES. WE ARE UNABLE TO BILL INSURANCE/MEDICAID WITHOUT THIS INFORMATION.

IF THEY ARE NOT COMPLETED YOU WILL BE BILLED.

Emergency Contact Information

In case of an emergency where we are unable to contact you, this page will be given to emergency personnel. Please fill out all spaces and note any other comments we may need to know.

Who do we contact in case of emergency?

- Emergency Contact #1 ____
  Name relationship to child phone number

- Emergency Contact #2 ____
  Name relationship to child phone number

If we are not able to reach either contact person, do we have your permission for Jarvis Pediatric Therapy, Inc. to contact 911/emergency services?

YES circle one NO

Medical History significant for emergency services. (i.e. asthma, diabetes, etc.)
____
____

Drug/Food allergies ____

Pediatrician ____

Hospital of Choice ____

Please list any and all adults (other than yourself) that DO have permission to pick up your child from therapy: ____
____
____

Please list anyone that does NOT have your permission to pick up your child from therapy:
____
____
____

Authorizations, Acknowledgements, and Agreements

Child's Name: ______________________________ Date of Birth: ___________

Legal Guardian (PRINT):_________________________

1. Authorization for Evaluation and Treatment
   I authorize physical (including orthotics), speech, and/or occupational therapy evaluation(s) and treatment for the above said child as ordered by my child's physician.

   ______________________________________ ________________________
   Signature Date

2. Acknowledgement of Privacy Practices
   I acknowledge that I have received a copy of Jarvis Pediatric Therapy, Inc.'s Notice of Privacy Practices.

   ______________________________________ ________________________
   Signature Date

3. Authorization for Release of Medical Information
   I, the legal parent/guardian of the above said child, do hereby give my permission to Jarvis Pediatric Therapy, Inc. to use my child's medical records for any purpose deemed necessary.

   ______________________________________ ________________________
   Signature Date

4. Consent for Child Observation and Intern/Student Interaction
   I, the legal parent/guardian of the above said child, understand that Jarvis Pediatric Therapy, Inc. is a teaching facility. I give permission for my child to be observed through supervised observations undertaken as part of an academic internship, practicum, and/or observation requirement for students. Interns may be used in a support capacity or as administrative assistants. They may participate in partner activities with my child while his/her therapist is in direct supervision. When reflecting on the observations, students will use codes to protect my child's identity and right to confidentiality.

   ______________________________________ ________________________
   Signature Date

5. Authorization to Photograph/Video for Promotional Use
   I, the legal parent/guardian of the above said child, give Jarvis Pediatric Therapy, Inc. the right and privilege to photograph/video my child for the use of developing and publicly releasing promotional information. I understand that my child's image may be viewed in the form of magazines, brochures, posters, and Jarvis Pediatric Therapy website (jarvistherapy.com). No identifying information will be revealed.

   ______________________________________ ________________________
   Signature Date

6. Authorization to Photograph/Video for Instructional Use
   I, the legal parent/guardian of the above said child, give Jarvis Pediatric Therapy, Inc. the right and privilege to photograph/video my child for educational and instructional purposes. I understand that videos, and/or photographs of my child may be viewed and discussed with other healthcare professionals or parents of the child. These videos/photographs will be deleted after use and no identifying information will be evident.

   ______________________________________ ________________________
   Signature Date

7. Social Media Waiver
   I, the legal parent/guardian of the above said child, hereby authorize Jarvis Pediatric Therapy, Inc. to publish on social media (Facebook). No identifying information will be shared.

   ______________________________________ ________________________
   Signature Date

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Payment Authorization and Financial Agreement

Please review the financial agreement for our practice. By signing this letter you are agreeing to all the terms in it.

I authorize payment of medical benefits to be made directly to Jarvis Pediatric Therapy, Inc. for services rendered. I understand that while insurance may cover some of my expenses, I will be personally responsible for anything not handled by my insurance. I understand that it is my responsibility to understand the coverage and limitations of my insurance. I agree to either fully pay or set up a payment plan and begin payment for all charges within 30 days of the receipt of my child's patient statement. Failure to pay outstanding balances will result in additional charges for collection and/or attorney's fees.

________________________________ ________________________________

Signature Date

HIPAA AUTHORIZATION

Child's Name: ______________________________ Date of Birth: __________________________

I hearby authorize Jarvis Pediatric Therapy, Inc. to release or obtain my individually indentifyable information, including contact information, pictures of my child, information about physical health and/or mental health, physical or mental condition, healthcare or other services, and payment for services.

I understand that:

- I am entitled to a copy of this form
- A copy of the permission form is as valid as the original
- I may revoke this authorization at any time by notifying Jarvis Pediatric Therapy, Inc. in writing. This will not affect any action Jarvis Pediatric Therapy, Inc. took in reliance on this authorization before it was revoked.
- If I refuse to authorize disclosure of my child's unrelated healthcare information, then Jarvis Pediatric Therapy, Inc. will not deny services.
- Once information is released to a third party, according to this authorization, Jarvis Pediatric Therapy, Inc. cannot prevent its re-disclosure.
- This authorization does not limit the ability of Jarvis Pediatric Therapy, Inc. to use or disclose my child's health information as otherwise permitted by state and federal law.
- Disclosed health information may be oral or written.

Print Parent/Legal Guardian's Name: ____

Describe Relationship to Patient: ____

Parent/Legal Guardian's Signature: _______________________________ Date: _________________

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How did you hear about us?

My physician recommended you: ____

A friend/relative told me:____

I found you on Facebook/Instagram:____

I searched the web:_____

I know one of your employees:______

A current or former patient told me about you:___ who?
____

I saw your flyer:_____ where? _____________________

I saw your team members at an event:______ which one?
____

I chose based on your physical location for convenience:_____

Other:____
____
____
____
____
____

Patient History

Patient Name: ______________________________ Date :____________________

Date of Birth: ____________ Age: ______ Primary Care Physician _______________

Diagnosis: ____

Primary language spoken in home: ____

Primary goals (what are your concerns):_____________________________________

____

____

Infant History

Complications/illness/infections/stress during pregnancy ___________________________

Possible drug/alcohol use during pregnancy ___________________________________

When did mother discover she was pregnant? __________________________________

Was mother on bed rest? ____

Gestational age (weeks)- premature/post-mature/full term ________________________

Complications during labor/delivery ____

Forceps/vacuum/c-section? ____

Birth Weight ________ Breast fed/How long? _________Frequently spit up? _________

Problems with feeding?____

Irritable/Happy/Quiet baby? ____

Sleeping problems as a baby? ____

Did baby arch head/back when upset? _____________ Colic? ________ Reflux? _______

Did baby gain weight appropriately? ______________________________________

Other comments on infancy ____

____

Developmental History

When did child

Roll over ______________________

Sit up ______________________

Crawl ______________________

Stand ______________________

Walk ______________________

Say 1st word ______________________ What was it? ________________

Say 1st sentence ______________________ What was it? ________________

Toilet trained ______________________

Dress self ______________________

Fasteners ______________________

Tie Shoes ______________________

Wean from bottle/breast ________________________
Drink from sippy cup ________________________
Wean from pacifier ________________________
Drink from regular cup ________________________

Developmental concerns? ____
____

Medical History

Allergies? ____________________________ Seizures? _________________________________

Injuries? _____________________________ Hospitalizations?___________________________

Vision/Glasses? _______________________ Surgeries?_________________________________

Ear infections? ________________________ Other precautions/concerns? ________________

Medications: ____

Any prior therapies (when, where, for what and how long)?____________________________

____

____

Other medical information: ____

Social History

Who lives in child's primary residence (names & ages) _______________________________

____

Was child adopted? If so when (at what age)? _______________________________________

Does child live with biological parent (s)? ____

Are biological parents married/divorced/separated? __________________________________

Possible history of abuse?____

Other stressors in child's life (death, illness, change in living situation, etc) _____________

____

Does child appropriately play with peers? ______________ Does child have friends? _________

Does child engage in pretend play? ____________________ Does child make eye contact? ______

Does child get into trouble at home? ____

Child's hobbies ____

Other social concerns ____

____

School/Daycare History

Does child attend school or daycare (name) ____

Does child take a nap during the day (if yes, when?) __________________________________

What does child do during the day? ____

Teacher name _______________________________ Grade ____________________

Has child repeated a grade? _______________________ If so, which grade? ______________

How many teachers/children are in your child's class? ________________________________

What is your child working on at school? ____

Is child able to write legibly? (if appropriate) ____

Does child get into trouble at school/daycare? _______________________________________

Is your child on an IEP or 504 Plan (category?) ______________________________________

Other school concerns____

Self-Care
Can child:

Put on clothes ______________________
Put on shoes/socks __________________
Button/unbutton shirt/ pants _________
Zip/unzip pants/coat _______________
Brush hair ________________________
Use a fork ________________________
Make a sandwich __________________
Take off clothes ______________
Take off shoes/socks __________
Tie shoes ___________________
Brush teeth __________________
Feed self ____________________
Drink from a cup _____________
Use the microwave ___________

Permissions for snacks and/or prizes while at the clinic:

1. Food is often around the clinic for various reasons (kids' birthdays, leftover doughnuts or cake for staff recognition, holiday goody gifts from families, Goldfish crackers for reinforcement in therapy, food from feeding therapy room, etc.). Aside from any allergies that have already been indicated in patient intake paperwork, please let us know if your child ***is*** or ***is not*** allowed to be given food while at Jarvis.

_____ **YES**, my child is allowed to be given snacks/food while at Jarvis.
_____ **NO**, my child is NOT allowed to be given snacks/food while at Jarvis.

Comments: ____
____
____
____

2. We offer all the children the choice of a treasure box prize or candy as their prize for working hard in therapy. In OT, chewing gum is a common practice. Please let us know if your child ***is*** or ***is not*** allowed to be given treasure box, gum and/or candy while at Jarvis.

_____ **YES**, my child is allowed to be given treasure box prizes while at Jarvis.
_____ **NO**, my child is NOT allowed to be given treasure box prizes while at Jarvis.
_____ **YES**, my child is allowed to be given gum and candy while at Jarvis.
_____ **NO**, my child is NOT allowed to be given gum and candy while at Jarvis.

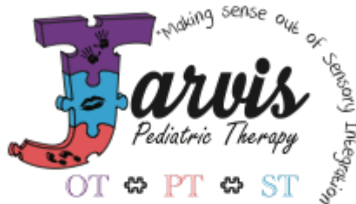
Comments: ____
____
____
____

I (name) ________________________________, as of (date)_____________________________ give permission to Jarvis Pediatric Therapy Inc. To take photos/videos of my child: (child name) ___________________________, for the use of Social Media (Facebook) and advertising including website, flyers, etc.

Thank you,
Wendy Jarvis, Owner

Parent Signature: ________________________________

Date: ___________________________



AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:	
Client Date of Birth:	
Parent Name:	

I hearby authorize Jarvis Pediatric Therapy to share information with the following individuals/ organizations:

	Facility Type	Facility Name
	Hospital	
	School	
	Therapy Company	
	Developmental Center	
	Physician	
	Other	

This authorization applies to:

	Information
	Speech Therapy Evaluation
	Occupational Therapy Evaluation
	Physical Therapy Evaluation
	Developmental Evaluation
	Psycho-Educational Evaluation
	IQ Testing
	MBSS (Modified Barium Swallow Study)
	Co-Ordination of care with school personnel
	Co-Ordination of care with feeding therapy
	Other:

_______________________________ Parent Signature

_______________________________ Date

PLEASE COMPLETE THIS FORM IF YOU ANTICIPATE A SPEECH-LANGUAGE EVALUATION

There are 9 areas listed below that are commonly addressed in speech therapy. Circle the areas you believe your child is having difficulty with. Check each characteristic that applies to your child within each area. Be as descriptive as possible in the 'other' section of each area. If there is an asterisk (*****) next to an area you circled, there may be additional paperwork needed from you regarding specific concerns. This information will help the Speech-Language Pathologist in assessing and treating your child efficiently and effectively. <u>If your child is ten years or older, you must provide the clinic with a recent IQ test before they can be evaluated for speech.</u>

*SPEECH

__says sounds incorrectly
__leaves sounds off
__is difficult to understand
__can't repeat correct sound
__lisps
__is not making any sounds
__other:______________________
____
____

VOICE

__abnormal vocal quality
__nasal quality to voice
__hoarse
__breathy vocal quality
__constant throat clearing
__volume control issues
__other:______________________
____
____

COGNITION

__poor memory
__inability to problem solve
__poor attention
__disorganized
__rigid thinking, not flexible
__behavior issues (specific)
__poor emotional control
__other:______________________
____
____

*RECEPTIVE LANGUAGE

__does not follow directions
__seems to not understand
__can't make a choice
__can't answer questions
__limited vocabulary
__doesn't always respond
__can't identify objects
__struggling in school
__other:______________________
____

*EXPRESSIVE LANGUAGE

__not talking yet
__does not gesture
__uses incorrect grammar
__difficulty expressing self
__will not repeat
__can't formulate a sentence
__doesn't label objects
__difficulty asking questions
__cannot retell a story
__limited written expression
__other:______________________
____
____

LITERACY

__sound blending issues
__difficulty rhyming
__limited sight words
__other:______________________

FLUENCY

__speaks too fast
__speaks too slow
__repeats sounds "c c c cat"
__stutters
__stumbles over words
__other:______________________
____

PRAGMATICS

__easily gets off topic
__difficulty making friends
__minimal or no eye contact
__random statements
__inappropriate
__doesn't play with others
__struggles with social cues
__minimal nonverbal cues
__other:______________________
____
____

*FEEDING/ORAL MOTOR

__picky eater
__refuses entire food groups
__doesn't chew food
__drools
__tongue thrust
__pockets food in mouth
__coughs, gags, chokes
__other:______________________
____
____

Sensory Processing and Motor Control Questionnaire

Patient Name:________________________________ **Date:**_______________________

Scoring: Use an “X” to mark items that apply to your child, deleting/modifying parts of items as appropriate. Mark “XX” on items which are areas of particular concern to you. Use “P” to mark items that used to be a problem, but now is resolved. Please add comments, examples, information reported by others, and additional information on the right side of the mage next to item. Include information reported by teacher concerning school behavior.

Vestibular (Movement and Balance)

___ Difficulty sitting still

___ Becomes overly excited after movement activity

___ Preoccupied with movement; seeks intense movement: spins, twirls, bounces, jumps, rocks

___ Avoids movement equipment on playground

___ Plays on _____________________________________ at playground

___ Shakes head vigorously, assumes upside down position frequently

___ Uncomfortable on elevators, escalators, or has motion sickness

___ Excessive dizziness or nausea from swinging, spinning, or riding in a car

___ Poor negotiation on uneven surfaces

___ Loses balance easily; fearful to changes in balance

___ As an infant, tended to arch back when held or moved

___ Avoids activities in which feet leave the ground

___ Fear of falling when no real danger exists

___ Trips easily; clumsy/uncoordinated

___ Poor sense of rhythm

___ Fear of heights or climbing

___ Fearful or resistant when ascending, descending stairs (seeks hand, railing, or walls)

___ Dislikes being moved

___ Resists having head tilted backward

___ Fearful of being tossed in air or turned upside down

___ Moves stiffly, as a single unit

___ Holds head upright when leaning or bending over; dislikes summersaults

Gross Motor Control-Proprioception (Muscle and Joint Awareness/Function)

___ Difficulty with hopping ___, jumping ___, skipping ___, running ___, compared to others his/her age

___ Difficulty moving; is slow when sustaining posture

___ Unable to pull up on monkey bars with flexion of arms and legs while moving from bar to bar

___Avoids age-appropriate participation in group gross motor activities

___ Appears stiff and awkward in movements; head, neck, and shoulder rigidity

___ Clumsy __ Confused how to move body ___ Bumps into things ___Falls out of chair

___ Tendency to confuse right and left when following verbal directions

___ Reluctant in playground participation; seeks adults instead

___ Doesn't extend arms when falling to protect head

___ Difficulty grading movement; uses too little ___ or too much power/force ___

___ Unstable posture, easily thrown off balance

___ Tends to slump in chair with rounded back, head forward and neck extended

___ Props head on hand or lays head on forearm

___ Prefers ___ Avoids crunchy or chewy food

___ Avoids vibratory devices (barber's clippers, electric toothbrushes)

___ Walks on toes frequently

___ Drags feet or poor heel-toe pattern when walking

___ Wide based stance

___ Turns whole body to look at a person or object

___ Resists new physical challenges, saying "I can't" without attempting

___ Seems weaker or tires more easily than peers

___ Appears lethargic

___ Seeks sedentary play

___ Leans on objects/people for stability

___ Weak grasp

___ Cannot lift heavy objects, avoids heavy work

___ Moves with quick bursts of activity rather than sustained movement

___ Achieves standing posture by pushing off floor with hands

___ W-sits (sits with bottom on floor between legs with knees bent)

___ Loose joints

___ Collapses onto furniture

___ Seeks vibratory stimulation

___Craves tumbling or wrestling

___ Frequently gives ___ requests___ firm or prolonged hugs

___ Plays roughly with people or objects

___ Seeks opportunities to fall, crashes into things

___ Stamps or slaps feet on ground when walking

___ Kicks heels against floor or chair

___ Bangs sticks or other objects along wall or fence

___ Cracks knuckles

___ Sets jaw when applying effort with extremities

___ Grinds or clenches teeth, bites, or chews objects or clothing

Tactile Function

___ Excessive reaction to light tough sensation (anxiety, hostility, aggression)

___ As an infant, not calmed by cuddling/stroking

___ Difficulty standing in line or close to other people

___ Tenses when patted affectionately

___ Negative reaction to unseen, unexpected touch

___ Clothes cover entire body regardless of weather

___ Wears minimal clothes regardless of weather

___ Avoids certain textures of clothing, materials

___ Avoids putting hands in messy substances/getting dirty

___ Engages in self-injurious behavior(s)   List:_____________________________________

___ Likes to be wrapped tightly in sheet or blanket, seeks tight spaces

___ Engages in self-stimulatory behavior(s)   List: ________________________________

___ Frequently adjusts clothing as if feeling uncomfortable

___ Stands too close to people to a point of irritation

___ Touches everything, can't keep hands to self

___ No apparent response to being touched or bumped

___ Avoids busy, unpredictable environments

___ Intent on controlling/manipulating to keep environment predictable

___ Resistive to personal grooming activities, such as haircut, nail trimming, other (please list)
____

___Extreme reaction to tickling

___ Examines objects by placing in mouth

___ Appears under ____ over ___ sensitive to pain

___ Socks have to be just right: no wrinkled or twisted seams

___ Hyper-responsive gag reflex

___ Picky eater. List food preferences: ____

___ Limits self to particular foods/temperatures. List: _________________________________

___ Hands seem to be unfamiliar appendages

___ Difficulty identifying which body part is touched when eyes are closed

___ Untidy/ messy dresser

___ Shoes worn loose or untied or on wrong feet

___ Unable to identify familiar objects via touch

___ Poor awareness of body part relationships

___ Rubs or scratches a spot that has been touched

___ Avoids ___ Seeks being barefooted on textured surfaces (grass, sand)

Auditory

___ Overly sensitive to loud sounds or noises

___ Over reacts to unexpected or loud noises (sirens, etc.)

___ Irrational fear of noisy appliances

___ Covers ears to shut out auditory input

___ Hears sounds other don’t hear or before others notice

___ Sensitive to certain voice pitches

___ “Tune out” or ignores sounds nearby

___ Unable to pay attention when there are other sounds nearby

___ Can only work with stereo or TV on

___ Flat; monotonous voice

___ Unable to sing in tune

___ Hums, sings softly, ‘self-talks’ through a task

___ Language is hard to understand

___ Voice volume is too soft____ too loud___

___ Needs visual cues to respond to verbal commands or requests

___ Needs increased volume to respond

___ Mispronounces words (bisghetti, mazagine, etc.)

___ Doesn’t respond when name is called

___ Inattentive to what is said

___ Fidgets while listening

___ Misunderstands what you say

___ Has difficulty remembering melodies

___ Confuses similar sounding words

___ Doesn’t seem to hear the beginning ____, middle____, end ___, of a statement

___ Frequently asks you to repeat what you have said

___ Slow or delayed responses

___ Difficulty sequencing the order of events when telling a story/describing an event

___ Has difficulty finding words to use; hesitant speech

___ Tendency to stutter

___ Not precise in work selection

___ Limited use of descriptive vocabulary

___ Participates little in conversations

___ Enjoys strange noises or repeats the same sound over and over

___ Seeks out toys or objects that make sounds

___ Craves music or other specific sounds

Oculo-Motor Control & Visual Perception

___ Poor depth perception; examples: ducks when ball approaches, difficulty with stairs

___ Poor awareness of space in relation to things around self

___ When reading, skips words/lines ___, loses place ___, reads slowly ___, uses finger as marker ___

___ Poor reading comprehension

___ Letter/number/word reversals

___ Overly sensitive to lights/sunlight

___ Difficulty tracking a moving target without moving head

___ Poor visual monitoring of hand when writing/manipulating objects

___ Poor eye contact

___ Dislikes having vision occluded or being in the dark

___ Difficulty with near/far accommodation (copying from blackboard)

___ Squints ___, bloodshot eyes ___, eyes tear ___, raise eyebrows ___, rubs eyes ___

___ Gets lost easily, has poor sense of direction

___ Poor visual monitoring of environment

___ Hyper vigilant or visually distracted

___ Difficulty with ___ or enjoys ___ puzzles

___ Writing illegible ___ poorly spaced/places on line or page

___ Dislikes ___ or enjoys ___drawing

___ Difficulty finding objects in complex backgrounds

___ Over-stimulated by busy visual environment

___ Keeps eyes too close to work

___ Tilts head ___, props head ___, lays head on arm with desk work ___

___ Uses peripheral more than central vision

Fine Motor Control

___ Right___ Left___ handed

___ Switches hands: is primarily ___ handed

___ Poor desk posture (slumps, leans on arm, head too close to work, tilts head to side)

___ Difficulty grasping or maneuvering scissors

___ Difficulty cutting lines

___ Difficulty drawing ___, coloring ___, tracing ___, copying ___, or avoidance of these activities ___

___ Difficulty using both hands to: do same movement ___, do different movements with each hand___

___ Excessive body movements while seated at desk

___ Pencil lines are too heavy ___, light ___, or wobbly ___

___ Difficulty for age drawing forms, letters, or numbers

___ Pencil grasp pattern is immature ___, too tight ___, or too loose ___

___ Changes grasp pattern on pencil and other tools

___ Atypical alignment of the paper while drawing or writing

___ Does not stabilize paper when drawing or writing

___ Difficulty coloring within the lines

___ Difficulty managing fasteners and tying shoes

Taste and Smell

___ Highly sensitive to common odors or faint odors unnoticed by others

___ Does not seem to notice unpleasant smells

___ Will not taste food prior to smelling it and approving of its smell

___ Prefers bland foods ___, highly seasoned foods ___

___ Hypersensitive to body odors such as breath or scents of perfumes, soaps, etc.

___Tends to be overly focused on the taste or smell of non-food items

Suck, Swallow, Breathe Synchrony

___ Difficulty using straw ___, blowing bubbles ___

___ Poor lip closure on utensils when eating and drinking

___ Limited on skill with blow toys

___ Able to whistle

___ Poor saliva control; drooling

___ Tongue thrusts

___ Chokes easily on liquids and/or solids

___ Shallow breathing pattern

___ Holds breath support for speech, tends to gasp for air

___ "Breathy" speech

___ Speech volume barely audible

___ Puts hands on hips to increase lung capacity

___ Mouth breathing

___ Lower rib cage flared

Self-Care

___ Feeds self neatly with eating utensils

___ Prefers to eat with fingers___, is a messy eater ___

___ Difficulty undressing self___; Unable to undress self___

___ Difficulty dressing self ___; Unable to dress self ___

___ Snaps ___, Zippers ___, Buttons ___, are difficult ___ or impossible to manage ___

___ Bathes self___, able to wash hair___, able to brush teeth ___, independently

Motor Planning and Bilateral Motor Coordination

___ Accident prone

___ Limited rotation of pelvis and/or shoulder girdle around central core of body

___ Poor coordination of hands and/or legs for symmetrical ___ asymmetrical___ movements

___ Poor eye teaming

___ Difficulty performing two different tasks at the same time (cut meat using knife and fork, hold and turn paper while cutting with scissors)

___ Difficulty crossing body midline with head or extremities

___ Letter/number reversal

___ Poor reading speed and/or comprehension

___ Ambidexterity/mixed hand dominance

___ Difficulty with projected action sequences (catching a ball, bat a ball)

___ Difficulty performing a new motor response strategy, as opposed to a habitual one

___ Difficulty with timing ___, rhythm ___, sequencing movements ___

___ Disorganized or inefficient approach to tasks

___ Prefers talking to doing

___ Problems in construction and/or manipulation of materials

___ Poor articulation

___ Handwriting deficits

___ Unable to conceive and organize a plan of action

___ Insufficient body scheme awareness

___ Immature ability to draw a person

___ Inefficient/disorganized with self-help skills

___ Poor gross ___, fine ___, motor control of body when attempting new activities

___ Confuses left and right

___ Difficulty with verbal cues to move or position body or to play “Simon Says”

___ Difficulty positioning self squarely on furniture/equipment

___ Poor hand eye coordination

___ Fails to adapt body posture to demands of activity

___ Extraneous movement relative to demands of task

Emotions/Social Behaviors

___ Can’t sit still; is hyperactive

___ Impulsive, does not think before acting

___ Poor ability to shift gears; self-regulate behavior

___ Easily distracted, difficulty staying on task unless doing something of particular interest

___ Intense, explosive, or prone to tantrums

___ Displays aggression toward self___ or toward others ___

___ Easily frustrated ___, anxious ___, overwhelmed ___

___ Clingy, whiny, or cries easily

___ Stubborn, inflexible, or uncooperative

___ Poor eye contact

___ Poor self-concept/low self-esteem

___ Highly sensitive/can’t take criticism

___ Feelings of failure or frustration

___ Gives up easily

___ Poor sleep/wake cycles

___ Restless ___, deep ___, light ___, sleeper

___ Difficulty making choices ___; needs guidance to make good choices

___ Fearful (what of) ____

____

___ Unable to adjust to changes in routine

___ Slow to, or unable to make timely transitions

___ Prefers company of adults or older children

___ Easily discouraged or depressed

___ Enjoys team sports

___ Tends to be a leader ___, follower ___, loner ___

___ Poor loser

___ Fails to see humor in situations

___ Needs more protection from life than peers

___ Difficulty expressing emotions verbally

___ Overly serious

___ Active, outgoing, enthusiastic