DEVELOPMENTAL MOTOR SKILLS

CHILDS NAME: _____

BIRTHDATE: _____

DATE: _____

AGE: _____

Help us understand your child's motor skills development:

YES NO

☐☐ Does your child have any durable medical equipment?_____

_____

☐☐ Have you noticed any hand or foot preference? _____

_____

☐☐ Who lives in the home? _____

_____

☐☐ Are you aware if your child plays in the same manner as other children their age? Please describe how your child typically interacts with others during play. _____

_____

_____

☐☐ Does your child wear glasses or do you have any visual concerns for your child? _____

_____

☐☐ Does your child have hearing aids or do you have any concerns of hearing problems for your child._____

☐☐ Can your child identify any letters/shapes/colors/numbers? _____

_____

☐☐ Can your child write any or all letters/shapes/digits (0-10)? _____

_____

☐☐ Are you aware if your child can copy and or trace?

_____

☐☐ Do you have any handwriting concerns for your child? Explain:_____

_____

☐☐ Do you have any grasping concerns for your child? _____

_____

☐☐ Does your child eat a regular diet? _____

_____

☐☐ Can your child use a spoon and fork? _____

_____

☐☐ Do you have any concerns about your childs eating of foods or eating behaviors?

_____

_____

☐☐ Does your child brush their own hair? If no, do they tolerate hair brushing/styling from an adult?

_____

_____

☐☐ Does your child brush their own teeth or participate in any of the process to prepare the toothbrush or toothpaste? If none, do they tolerate toothbrushing from an adult?

_____

_____

☐☐ Does your child attempt to keep the area surrounding their mouth clean after brushing? If not, do they allow an adult to clean them?

_____

_____

Please tell the assistance level your child needs to put on or take off any of the following items of clothing either: 1-can do without adult help, 2-needs some adult help or 3-completely dependent on the help of an adult.

_____socks:

_____shoes:

_____pants:

_____underwear:

_____shirt:

_____tying shoes:

_____buttoning/unbuttoning buttons:

_____velcro:

_____zipper

How much help does your child need when using the restroom, please include help needed with clothing, wiping, and hand hygiene? _____

_____

☐☐ Is showering/bathing tolerated without resistance? _____

_____

☐☐ How many hours a night does your child sleep? Do they take a nap regularly everyday, if so for how long? _____

☐☐ Do you have any sensory concerns for your child? Explain: _____

_____

_____

☐☐ Please list any behavioral concerns you have for your child. Explain: _____

_____

_____

☐☐ Do you have any additional areas of concern not previously addressed? _____

_____

_____

Submit Patient Paperwork