Client/Parent/Caregiver/Teacher Occupational Therapy Questionnaire
SENSORY PROFILE, MOTOR, DEVELOPMENTAL AND, MEDICAL HISTORY

Therapist use only:
Speech:

Regulatory:

Tactile:

Proprioception:

Vestibular:

Body Awareness:

Praxis:

Visual:

Auditory:

Oral Motor/etc.

Client's Name:____________________________ Date:________

Address:____

Today's Date: ______Year, ______ Mo., _______Day

Birth Date: ______Year, ______ Mo., ________Day

Chronological Age: ______Years, ______Mo(s), ______Day(s)

Form Completed by:_______________________________________

Relationship to Client:_____________________________________

Medical diagnosis (if any):__________________________________

Who provided the diagnosis:_________________________________

Age diagnosis was given:____________________________________

Parents Names (if client a minor):___________________________

____

PRENATAL HISTORY

	Yes	No
Pregnancy: 1. Were there any illnesses, injuries, fainting spells, bleeding anemia, operations or any other difficulties during mother's pregnancy?		
2. Were any drugs or medication taken during mother's pregnancy? Specify:		
Delivery: 1. Was the pregnancy full term?		
2. Was the pregnancy premature? (Give months and weight)		
3. Was it an unusual delivery? (Breech, Caesarian, specify)		
4. Was the labor normal?		
5. Was the labor abnormal? (Prolonged, short, specify)		
6. Were forceps used? (Give details)		
7. Was medication given during delivery? Specify.		

Comments:

Birth History

	Yes	No
1. Was the individual considered to be a low birth weight? Specify.		
2. Were there complications such as: a. cyanosis?		
b. jaundice?		
c. congenital defects?		
d. limpness?		
3. Was there a need for: a. oxygen?		
b. transfusions?		
c. tube feedings?		
4. Were there any feeding difficulties? Specify.		
5. Was the individual bottle-fed?		
6. Was the individual breast-fed?		
7. Did the individual have problems sucking?		
8. Did the individual have problems swallowing?		
9. Was the length of the individual's stay in the hospital unusually long? Specify.		

Comments:

Medical History

	Yes	No
1. Has the individual had any of the following? Please give dates and indicate whether The individual had the illness or was immunized. a. Meningitis		
b. Measles		
c. Chicken Pox		
d. High Fevers		
e. Mumps		
f. Whooping Cough		
g. Scarlet Fever		
i. Diabetes		
j. Lung or Bronchial Difficulties		
k. Heart Trouble		
l. Seizures (indicate when, how often)		
m. Allergies		
n. Excessive Vomiting		
o. Tuberculosis		
p. Polio		
q. Physical Injuries/Surgical Procedures? If yes, describe:		

Medical History (Cont.)		
2. Is there a vision problem? If yes, describe.		
3. Has there been an eye evaluation and is there a diagnosed visual problem? Date: Evaluated by Whom? (Please give name) Diagnosis: Ophthalmologist? Developmental Optometrist? Other?		
4. Does the individual have a hearing problem? Had an evaluation? By whom? Date: Describe problem. Has individual received Auditory Integration Training, Tomatis, Therapeutic Listening, or any other 'Listening Intervention Program'? Name of program____________________ Where?____________________ Dates?____________________ Other treatment?		
5. Is the individual currently on medication? Medication: Dosage (mg & times/day) Purpose:		

Comments:

DEVELOPMENTAL HISTORY

1. At what age did the individual (Please specify ages as near as possible):

a. Roll over both ways?	
b. Crawl?	
c. Sit alone?	
d. Walk?	
e. Speak his/her first word (What was it?)	
f. Speak his/her first sentence (What was it?)	
g. Drink from a cup independently?	
h. Use a spoon independently?	
i. Feed him/herself independently?	
j. Put on a shirt independently?	
k. Button independently?	
l. Dress him/herself independently?	

Use the following key to mark your responses:

1. **Always:** when presented with the opportunity, the individual responds in the manner ***almost every time***, ***90-100 %***
2. **Frequently:** when presented with the opportunity, the individual ***usually*** responds in this manner, ***at least 50-75 %*** of the time.
3. **Occasionally:** when presented with the opportunity, the individual responds in this manner ***approximately 30 %*** of the time
4. **Seldom:** when presented with the opportunity, the individual **usually doesn't** respond in this manner, ***less than 25 %*** of the time.
5. **Never:** when presented with the opportunity, the individual **never** responds in this fashion, ***0%*** of the time

2. **Describe infancy**:

	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
a. Cried a lot, fussy, irritable, colicky?						
b. Was good, non-demanding?						
c. Slow to calm?						
d. Fussy eater?						
e. Was alert?						
f. Was quiet?						
g. Was passive?						
h. Was active?						
i. Liked being held?						
j. Was floppy when held?						
k. Was tense when held?						
l. Had good sleep patterns?						
m. Had irregular sleep patterns?						

Comments:

3. **Describe the individual presently; emotional / relational issues:**

Is or Does the individual…?:

	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
1. Mostly quiet, shy?						
2. Overly active?						
3. Self-absorbed?						
4. Tire easily?						
5. Talk constantly?						
6. Have poor impulse control?						
7. Restless?						
8. Stubborn, rigid, uncooperative, oppositional?						
9. Resistant to changes?						
10. Overreact & seem easily overwhelmed?						
11. Have difficulty being calmed once upset, or is unable to unwind and self-calm?						
12. __Argue a lot, __ express hostility, ___fight frequently?						
13. Usually happy?						
14. Have nervous habits or tics? If so describe:						
15. Have poor attention span?						
16. Frustrated easily?						
17. Have unusual fears, which may interfere with daily routines? Describe:						
18. Have sleep problems: sleeps overly much or not enough; trouble waking or trouble falling asleep?						
19. Rock self frequently?						
20. Clumsy?						
21. Have frequent temper tantrums, become quickly angered, explosive, easily enraged?						

Describe the Individual Presently (cont.):	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
22. Fall often?						
23. Apt to say, 'Everything drives me crazy'?						
24. Depressed, overly/easily discouraged?						
25. Tend to want to be in charge, be bossy or refuse to interact/play if it's not done their way?						
26. Blame others, unable to take responsibility for actions?						
27. Have difficulty making friends?						
28. (If a child) Prefers the company of older individuals or younger children?						
29. Self-isolate, withdrawn?						
30. Not interested or easily engaged with others?						
31. Avoid eye contact?						
32. Seem to have difficulty liking self, lacking self-confidence, apt to chastise self for being stupid?						
33. Lack a sense of humor, is overly serious?						
34. (Child) wets bed?						
35. As a child has/had trouble 'growing up'?						
36. Have difficulty learning new tasks (i.e. writing, throwing a ball, riding a bike, chores, work tasks, etc.)?						
37. Use inefficient ways of doing things?						
38. Need more protection from life than other individuals?						
39. Seem accident-prone?						
40. Become overly affectionate with others?						
41. Sensitive to criticisms?						
42. Have pronounced mood swings?						
43. Overly anxious much of the time, even with crippling anxiety, panic attacks?						
44. Display emotional outbursts when unsuccessful at a task?						
45. Have difficulty tolerating and feels out of control with changes in plans, expectations, or unpredictable situations?						
46. Have difficulty transitioning from one situation to the next?						
47. Dislike new situations?						
48. Express feeling like a failure, low self-esteem?						
49. A perfectionist and must do it just so or not at all?						
50. Have nightmares?						
51. Cry easily?						
52. Poor frustration tolerance?						
53. Have difficulty expressing emotions?						
54. Have difficulty separating from primary caretaker?						

Describe the Individual Presently (cont.):	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
55. Have difficulty perceiving/reading others' body language or facial expressions?						
56. Attempt to self-calm with 'self-stimming'? Describe:						
57. Act out aggressively? Please check appropriate: Hitting____, Scratching____, Kicking ____, Biting ____, and Other ______________________________________.						
58. Have episodes of self-injurious, self-mutilating behavior? Describe:						
59. Overly impatient?						
60. Moody?						
61. Have emotions lacking in range, depth, or apt to be inappropriate (too much, too little) in relationships?						

Comments:

SENSORY HISTORY

TOUCH / TACTILE SYSTEM

Does the individual…?

	Always	Freq	Occ	Seldom	Never	N/A
1. Avoid getting "messy" (i.e. in finger paint, mud, paste, sand, glue, tape, lotions)? List please:						
2. Can't stand feeling gritty, sticky, slimy, slippery, gummy, greasy, prickly, or rough textures?						
3. Wash hands frequently?						
4. Dislike grooming (i.e. hair or face washed or wiped, haircutting, fingernail cutting)?						
5. Show sensitivity to certain fabrics, textures (i.e. particular about certain clothes, blankets or bed sheets)?						
6. Avoid being touched or contacted?						
7. Dislike being touched unexpectedly, especially by a stranger?						
8. Dislike someone approaching and putting an arm around their shoulder?						
9. Dislike shaking or holding another's hand, especially a stranger's?						
10. Dislike being cuddled, or hugged, except perhaps by parents, or partner?						
11. Dislike lotions/creams on skin?						
12. Dislike/dreads tooth-brushing or dental work?						
13. Isolate self from others?						
14. Becomes agitated or shuns crowds, being in a group elevators, malls, subways, shops, or busy city streets?						

TOUCH/TACTILE (cont.) Is or Does the Individual…?	**Always**	**Freq**	**Occ**	**Seldom**	**Never**	**N/A**
15. Limit themselves to particular food textures or food temperatures? List please:						
16. Show irritation to shoes or socks?						
17. Avoid going barefoot especially in the sand or grass?						
18. Avoid wearing shoes, love going barefoot?						
19. Rigid rituals in personal hygiene?						
20. Picky eater, especially regarding textures?						
21. Withdraw from splashing water?						
22. Have difficulty standing close to other people, or in a line?						
23. Have feelings of needing to mentally prepare self for situations when people are apt to touch you?						
24. Rub or scratch out a spot which has been touched, kissed?						
25. Gag easily with food textures, food utensils, tooth brush in mouth?						
26. Find clothing tags irritating?						
27. Display unusual need for touching certain toys, surfaces or textures (e.g.: ladies hose, silk and soft fabrics, or opposite – very rough surfaces)						
28. Chews/licks non-food objects? Specify:						
29. Eat/drink in a messy manner?						
30. Bang his or her head on purpose, now or in the past?						
31. Bang, pinch, bites or otherwise hurt him/herself/others intentionally or otherwise?						
32. Prefer long sleeved garments in warm weather, or short sleeved clothes in the cold?						
33. Feel either too hot or too cold most of the time?						
34. Show decreased awareness of temperature?						
35. Can't stand feeling sweaty/sticky in the summer?						
36. Reacts emotionally or aggressively to touch?						
37. Tend to feel pain less than others?						
38. Tend to feel pain more than others?						
39. Touch others and objects, 'everything in sight' to the point of irritating others?						
40. Mouth objects frequently (i.e. pencil, hands, clothing, etc.)? Specify:						
41. Dislike turtleneck tops, or rebel against tight fitting clothes, belts, elastic waistbands, etc.						
42. Dislike the feeling of jewelry (rings, bracelets, necklaces, earrings						
43. Adult client have discomfort with physical intimacy because all touching/being touched feels noxious?						
44. Not seem to notice when someone touches arm or back?						
45. Seem not to notice when face or hands are messy?						
46. Leave clothing twisted, disheveled on body?						
47. Crave rough play, hugs?						
48. Bump or push others frequently?						

TACTILE/TOUCH (cont.):
Comments:

For Therapist's Use Only:

Tactile Summary:
Under reactive #'s ____________________
Over reactive #'s ____________________
Mix reactive ____________________

PROPRIOCEPTION SYSTEM / BODY POSITION

Does the individual…?

	Always	Freq	Occ	Seldom	Never	N/A
1. Prefer to lie rather than sit or stand?						
2. Seek opportunities and likes to jump, crash, or fall without regard to personal safety, is a 'daredevil'?						
3. Seems to 'physically tackle' everything?						
4. Hang or lean on other people, furniture, objects even with unfamiliar people or situations (e.g. head always rests on arm while at a table/desk)?						
5. Seem to have weak muscles?						
6. Tire easily, especially when standing or holding a particular body position?						
7. Lock joints (e.g. elbows, knees) for stability?						
8. Walk on toes?						
9. Uses too much pressure when writing & breaks many pencil points.						
10. Seek out jumping on a trampoline for extended periods?						
11. Move stiffly, turns whole body to look?						
12. Have a weak grasp?						
13. Have difficulty lifting heavier objects?						
14. Prop to support self?						
15. Bumps, trips or pushes into others or objects?						
16. Crave rough & tumble play?						
17. Want to be weighed down with heavy blankets at night?						
18. As an infant, learn to walk with little or no crawling?						
19. As an infant crept on tummy rather than on hands and knees?						
20. Dislike vibrations from air conditioners, vehicles, furnaces, appliances: e.g. washer/dryer, blender, etc.?						
22. Crave vibration as with above listed items (#20)?						
23. Stuff food in mouth?						
24. Grind teeth?						
25. Chew on objects/toys excessively? (E.g. gum, shirt, fingers, nails, pencil, etc.)						
26. Pulls and twists things?						
27. Breaks toys or objects often but without meaning to?						

PROPRIOCEPTION / BODY POSITION (cont.) Does the Individual…?	Always	Freq	Occ	Seldom	Never	N/A
28. Pulls on fingers and cracks knuckles?						
29. Stands too close when talking to others?						
30. Seem unaware of where their body or body parts are, lose track of her/himself, or lose control of her/his body?						
31. Have trouble with constipation?						
32. Have/had trouble learning urinary control?						
33. Have/had trouble learning bowel control?						

Comments:

VESTIBULAR SYSTEM / MOVEMENT

Does the individual…?

	Always	Freq	Occ	Seldom	Never	N/A
1. Become anxious or distressed when feet leave the ground?						
2. Fear falling or heights?						
3. Dislike activities where head is upside down (i.e. somersaults) or rough-housing?						
4. Avoid climbing, jumping, bumpy or uneven ground?						
5. Become anxious/panicked walking down steps or riding an escalator?						
6. Fear stepping off of or up onto street curb?						
7. Seek all kinds of movement and this interferes with daily routines?						
8. Seek sedentary play/activity options; is very cautious and hesitant to take risks?						
9. Avoid playground equipment or moving toys, recreational activity involving movement?						
10. Amusement park rides completely avoided?						
11. Rock unconsciously during other activities (i.e. while watching TV, working, talking)?						
12. Seek all kinds of movement activities (e.g. merry-go-rounds, ferris wheel, rollercoaster, playground equipment, being whirled by adult)?						
13. Take excessive risks with movement, climbing, or play that compromise personal safety, is a 'thrill seeker' during recreation?						
14. Has trouble staying seated?						
15. Hold head upright, even when bending over or leaning?						
16. Become disoriented when bending over forward or backward, e.g. over a sink, or table, or to look up and back?						
17. Twirl/spin self frequently throughout the day?						
18. Stares at spinning objects?						
18. Hold onto walls or banisters?						
19. Become overly excitable after a movement activity?						
20. Turn whole body to look at you?						
21. Enjoys being upside down?						

VESTIBULAR SYSTEM / MOVEMENT/ (cont.) Does the Individual…?	**Always**	**Freq**	**Occ**	**Seldom**	**Never**	**N/A**
22. Poor endurance/tires easily?						
23. Appear lethargic?						
24. Rock in desk/chair/on floor?						
25. Poor sense of balance?						
26. Difficulty with coordination, balance and avoid balance games in sports, or on playground?						
27. Get dizzy easily (carsick or seasick while driving, in a boat, airplane, escalator, or elevator)?						
28. Dislike riding in a car?						
29. Feel anxious when experiencing sudden or fast movement, or when on an unstable surface, on swings, or a roller coaster?						
30. Dislike looking down from escalator, glass front elevator, out upper story windows, long flight of stairs, etc.						

Comments:

For Therapist's Use Only:

Vestibular Summary:
Under reactive #'s ____________________
Over reactive #'s ____________________
Mixed reactive: ____________________

AUDITORY SYSTEM

Does the individual…?

	Always	**Freq**	**Occ**	**Seldom**	**Never**	**N/A**
1. Respond negatively to unexpected or loud noses (siren, vacuum cleaner, truck passing, dog barking, thunder, hair dryer, school intercom, ceiling fan)? Describe:						
2. Become distracted or have difficulty functioning if there is noise around?						
3. Have difficulty working with background noise (e.g. fan, refrigerator)						
4. Unable to shut out constant noise?						
5. Have trouble completing tasks when the radio is on?						
6. Not respond when name is called?						

AUDITORY SYSTEM (cont.) Does the individual:	Aways	Freq	Occ	Seldom	Never	N/A
7. Specifically crave very soft, easy-going music or the opposite – louder, upbeat, or rock music? Specify:						
8. Enjoy strange noises? Seek to make noise for the sake of noise?						
9. Appear not to hear what you say?						
10. Hold hands over ears, become agitated in certain environments (cafeteria, gym, church, mall, etc.)?						
11. Runs from a loud environment?						
12. Demands only one person speaks at dinner table?						
13. Need directions repeated?						
14. Have a diagnosed hearing loss?						
15. Seem as if always on guard and anticipating loud, sudden, piercing sounds; or forever asking, "What was that?"						
16. Have a history of early childhood chronic ear infections?						
17. Startle to sounds which others don't react to?						
18. Talks louder than anyone else?						
19. Wants car radio be turned on louder or the opposite, that it be turned off or always lower?						
20. Seem oblivious within an active environment?						
22. Listen inconsistently to sound (sometimes seems to hear & sometimes not)?						
23. Frequently request information to be repeated?						
24. Have a difficult time remembering things they have learned auditorily?						
25. Have/had difficult time learning phonics?						
26. Talk self through a task?						

Comments:

For Therapist's Use Only:

Auditory Summery:

Under reactive #'s ____________

Over reactive #'s __________

Mixed reactive _________

VISUAL SYSTEM
Does the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Look away from tasks to notice all actions in the room?						
2. Resist eyes being covered?						
3. Express discomfort, squints, avoids, recoils from sun or other bright lights (i.e., sunlight through window in car or house) when others have adapted to the light?						
4.Want lights dimmed inside; wears sunglasses inside?						
5. Show pleasure when in the dark and prefer to be in the dark?						
6. Insist on wearing dark glasses when outside?						
7. Close one eye or tip head when looking or reading?						
8.Turns opposite direction from where teaching sitting?						
9. Look carefully or stares intensely at objects/people?						
10. Make letter reversals?						
11. Become frustrated when trying to find objects in competing backgrounds (e.g., an overfilled drawer., papers on a desk, shoes in a messy room, favorite toy in the 'junk drawer'?)?						
12. Have trouble scanning environment to find a toy, or will miss picking up pieces, not seeing them?						
13. Lose place in book or skip words when reading?						
14. Write illegibly?						
15. Have great difficulty copying from board at school or from book to paper?						
16. Have difficulty putting puzzles together?						
17. Have difficulty discriminating colors or shapes?						
18. Hesitate going up or down curbs or steps?						
19. Get lost easily?						
20. Find that eye contact is overwhelming, avoiding it or looks through or beyond person's face?						
21. Doesn't notice when people come into the room?						
22. Become excited/disorganized when there are a variety of visual objects, or excessive visual stimulation?						
23. Have trouble staying between the lines when coloring or when writing?						
24. Become annoyed by moving objects, flickering lights on T.V. or the computer monitor.						
25. Watches everyone when they move around the room?						
26. Become overwhelmed by busy visual fields, visual clutter, shopping or visiting densely packed visual environments (malls, grocery, fairs, sporting events)?						

Comments:

For Therapist Use Only:

Overreaction #'s ____________________
Underreactive #'s ____________________
Mixed Reactive ____________________
Oculomotor Difficulty ____________________
Visual-Spatial Difficulty ____________________

TASTE-SMELL / ORAL SENSORY-MOTOR

Does the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Deliberately smell objects?						
2. Routinely smell food?						
3. Show strong preference for certain smells? List which smells:						
4. Avoid putting toys or objects in mouth as an infant/ toddler?						
5. React negatively to smell? (Eg. "You stink!")						
6. Become aware and repulsed by smells at a distance which others are unaware of?						
7. Grimace at odors others don't notice?						
8. Feel light headed or sick from or negatively react to smell of chemicals in the environment?						
9. Not seem to smell strong odors?						
10. Refuse &/or gag with food of certain texture/taste/odor?						
11. Avoid certain tastes / smells that are typically part of a normal diet?						
12. Have food preferences that are narrow or limited? List please:						
13. Crave certain foods &/or eat only certain textures? List please:						
14. Dislike eating and have a tendency towards or is diagnosed with anorexia____, bulimia_____.						
15. Eat or drink in a messy manner?						
16. Have a hyperactive or over-reactive gag reflex?						
17. Have early sucking___, swallowing___, or chewing___, difficulties? (Please check)						
18. Drooled after 15 months of age?						
19. Stuff food / objects in mouth?						
20. Breaths through mouth instead of nose?						
21. Won't visit certain environments?						

Comments:

For therapist's use only:
Taste-Smell Summary:
Under reactive #'s ______
Over reactive #'s _______
Mixed reactive ________

COMMUNICATION / LANGUAGE

(Most of these questions may only be pertinent to the child or developmentally young individual)
Was/Is speech developmentally delayed? Yes___ No___
Does the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Show little or no interest in you ___, in inanimate objects ___? (Check appropriate item)						
2. Nonresponsive to simple relationship based interactions, e.g. you look at me, I don't look at you; smiles are not shared; a gaze is not followed or shared; individual is not aware or pleased with another person's overtures?						
3. General difficulty responding to another's overtures with emotion, facial or tonal expressiveness? -------- Limitations expressing these feelings - Comments: Frown/Displeasure --------------------------------------- Curiosity/Interest/Attentive/Alert Focus -------------- Anger/Crying Tantrums--------------------------------- Frustration --- Distress/Tears/Yells --------------------------------------- Hesitation/Indecisiveness -------------------------------- Fear/Withdrawal/Aloofness/Self-isolation ------------ Interest/Reach/Pursue/Persist--------------------------- Babbling/Jargoning --------------------------------------- Pleasure/Laughter/Giggles/Happy squeals ----------- Jealousy/Assertive demand/Anger ---------------------	----------	------	-----	---------	--------	-----
4. Difficulty responding to gestures with intentional and reciprocal gestures such as: Comments: Reaching out --- Turning away/Looks away/Pushes away ------------ Returning vocalization or looks --------------------- Nodding or Shaking Head --------------------------- Pointing -- Waving -- Other (describe)--- --						

COMMUNICATION/LANGUAGE (cont.)

Does the individual:

	Always	Freq	Occ	Seldom	Never	N/A
5. Difficulty initiating interactions using gestures: such as: Pulls you to place or object--------------------------- Reaches out to be picked up -------------------------- Pushes toy/food away if displeased or finished --- Other (describe)________________________________						
6. Difficulty carrying on a continuous reciprocal "conversation" using: Comments Gestures -- Communication/vocalization ------------------------- Words -- Phrases/sentences --------------------------------------- Facial expressions --------------------------------------- Touching/holding --						
7. Difficulty communicating: Wishes -- Intentions -- Feelings --- Using vocalization --------------------------------------- Gestures -- Words --- Phrases --- Sentences ---						
8. Difficulty using words reciprocally with another to: Communicate wishes ------------------------------------ Intentions --- Feelings ---						
9.Difficulty understanding what is said to them?						
10.Difficulty communicating with vocal tonal inflection and showing emotional variations.						

MOTOR STABILITY, BALANCE, POSTURAL PRAXIS

Can the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Climb over obstacles?						
2. Hop on one foot?						
3. Jump rope?						
4. Skip?						
5. Sit in a chair?						
6. Jump with both feet together?						
7. Ride a tricycle?						
8. Ride a two-wheeler (with or without training wheels)?						
9. Pump self on the swing?						
10. Kick a ball?						

FINE MOTOR / MOTOR PLANNING

Did/does the individual exhibit difficulty with…?

	Always	Freq	Occ	Seldom	Never	N/A
1. Cutting or pasting? ___before, ___now						
2. Small manipulative toys/objects? ___before, ___now						
3. Learning to hold a pencil or crayon in a three-point position? ___before, ___now						
4. A weak grasp? ___before, ___now						
5. Grasping objects too tightly or breaking lots of pencil points? ___before, ___now						
6. Trouble controlling release of objects?						
7. Tire easily? ___before, ___now						
8. Seem to be accident prone? ___before, ___now						
9. Positioning clothes on body? ___before, ___now						
10. Rhythm or alternating movements, like jump rope or hopscotch? ___before, ___now						
11. Tend to prefer sedentary activities, e.g. sits and plays with objects, watches TV, looks at/reads book, etc.? ___before, ___now						
12. Seem clumsy with toys/objects, unusually (though not purposefully)? ___before, ___now						
13.Learning manipulative hand skills (spoon, scissors, zipper, snaps, button)? ___before, ___now						
14. Move quickly from one activity to next, not sustaining or expanding plays? ___before, ___now						
15. Play tends to be simple schemes (i.e. dumping, putting in then taking out, stacking but not complex construction, grabbing and carrying to place, etc.)? ___before, ___now						
16. Play tends to be more repetitious with little variety. ___before, ___now						
17. Prefers structured recreational activities.						

Comments:

ACTIVITY LEVEL / AROUSAL & SELF-REGULATION

Does (or) Is the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Jump from one activity to another so frequently it interferes with play/work?						
2. Always 'on the go'?						
3. Prefer and spend most of the day in quiet sedentary play/work activities (watching TV, books, computers)?						
4. Avoid quiet play/work activities?						
5. Have difficulty paying attention?						
6. Have trouble refocusing attention if interrupted?						
7. Have difficulty being calmed once upset?						

ACTIVITY LEVEL, AROUSAL, & SELF-REGULATION (cont.)	Always	Freq	Occ	Seldom	Never	N/A
8. Have difficulty getting to sleep and/or waking up in the morning?						
9. Have difficulty sleeping through the night? (12-14 hrs) Please describe the sleep-wake cycle:						
10. Engage in repetitive self-stimulative schemes? Please describe:						

Comments:

SCHOOL/WORK PERFORMANCE / HANDWRITING

Does the individual…?

	Always	Freq	Occ	Seldom	Never	N/A
1. Need to prop head in his/her head while reading or writing at the desk?						
2. Mix up which hand or foot is left or right?						
3. Make reversals of letters or numbers when writing?						
4. Not have a clearly dominant hand by age 4?						
5. When writing, have to be reminded to hold paper down?						
6. Tire easily when writing?						
7. Tends to reverse numbers, e.g."teens" (14=41)?						
8. Have difficulty staying within lines on paper?						
9. Make letters of inconsistent size?						
10. Have poor spacing between letters, words, and lines?						
11. Have difficulty learning to hold pencil or crayon in three-point or tripod position?						
12. Have trouble differentiating capitals and small letters?						
13. Make strokes too heavy or too light?						

Comments:

SCHOOL & WORK PERFORMANCE/ORGANIZATION

Does the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Have difficulty with graded sizes of nesting or stacking objects/toys?						
2. Organize papers poorly?						
3. Have generally poor organizational skills (materials, homework assignments, school locker or desk, book bag, office and desk, home)?						
4. Have difficulty remembering schedules?						
5. Seem quite verbal but has difficulty organizing ideas sequentially and clearly?						

Comments:

SCHOOL PERFORMANCE / MATH

Does the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Count accurately?						
2. Have difficulty lining up columns or rows?						
3. Confuse concepts of lesser than or greater than, more, between, etc.?						
4. Have difficulty proceeding from rote counting of objects to abstract arithmetic/math problems without pictures?						
5. Have difficulty with complex multiplication or long division?						

Comments:

SCHOOL&WORK PERFORMANCE / BEHAVIOR

Does the individual…?:

	Always	Freq	Occ	Seldom	Never	N/A
1. Rush through assignments?						
2. Dawdle or take excessive time for work?						
3. Seem lazy and as if could do it if just tried harder?						

Comments:

Additional Comments: