PATHWAYS PEDIATRIC THERAPY
California Hand Rehabilitation, Inc

Please complete the following form to help us gain more information to determine the needs of your child:

Child's Name: _____ Date:_____

Child's Birthdate: _____ Age: _____ School: _____

Person answering questions: _____ Relationship to child: _____

Address: _____

Phone Number: _____

What are your primary concerns: _____

_____

Medical Diagnosis (if any) :_____ Date given: _____

Name of Evaluating Professional/Facility: _____

Significant medical history including major illness, accidents or incidents, and date of occurrence:

_____

_____

Has your child had therapy before? (please circle) **PT, OT, Speech, Behavior**

Where was the therapy given?_____

Birth History

Circle All Applicable: Full term Normal Birth weight Premature Breech Caesarian Difficult labor

Adopted? If yes, from where_____

Birth weight: _____ List any complications or other significant information regarding prenatal period/birth:

_____

_____

Developmental Milestones

Give approximate age of mastery, if known:

Rolling over: _____ Independent Sitting: _____ Crawling: _____

Walking: _____ First word: _____Using Sentences: _____

Potty Training: Day: _____ Night:_____

Establishment of Regular Sleep/Wake Cycles:_____ Falling Asleep Independently: _____

Please answer the following regarding your child's current level of performance:	**YES**	**NO**	**COMMENTS**
Mealtime:			
Eats at the table during family meals			
Is your child a picky eater?			
Grasps feeding utensils appropriately and efficiently			
Drinks from a straw			
Drinks from an open cup			
Is able to pour from a pitcher without spilling			
Eats without excessive spilling			
Notices food left on face			
Is able to maintain adequate attention to complete a meal (if no, include # of minutes)			
Is able to chew resistive foods (such as non-processed meats or dried fruits)			
Is free of gagging, reflux, or other swallowing concerns when eating			
Helps with set up and clean up at mealtime appropriately for age			
Is able to open food packaging appropriately: i.e. screw tops and ziplock baggies			
Other:			
Dressing:			
Is able to select and wear/tolerate clothing appropriate for the weather			
Is able to independently orient clothing			
Is able to dress independently (shirt, pants, socks, underpants) and in a timely manner			
Is able to manage fasteners :			
Velcro			
Zipper on pants			
Zipper on jacket			
Snaps			
Buttons			
Tie shoes			

Grooming/Bathing: **Does your child have any bathing and grooming issues?**	**YES**	**NO**	**COMMENTS**
Is able to wash/dry hands independently and thoroughly			
Is able to tolerate teeth brushing			
Brushes teeth independently and thoroughly			
Is able to wash and dry self independently			
Is able to tolerate having hair washed and brushed			
Is able to wash hair independently			
Is able to brush hair independently			
Is able to complete morning and evening routines independently and in a timely manner			
Dislike grooming			
Household **Does Your child help around the house and follow the routine?**			
Picks up after self when asked (for example, cleans up toys)			
Is able to wring out a washcloth			
Is able to use a broom and dustpan			
Completes age-appropriate household chores			
Able to organize his/her things			
Safety			
Walks/runs through uneven surfaces without falling (for example grass, steps)			
Places an arm out to protect his/herself when falling			
Moves through an environment without frequent bumps or crashes			
Appears secure to participate in climbing and movement activities			
Demonstrates safety awareness (for example, climbs safely, looks out for swings, balls, or cars)			
Respects boundaries for play (for example, stays in designated yard or play area when asked)			
Is able to maintain a calm, alert state when in a noisy, crowded, or novel environment			
Responds to adult instruction in a busy or noisy environment			
Refrains from self-injurious behaviors (for example, head banging)			

Fine Motor	**YES**	**NO**	**COMMENTS**
Have difficulty writing			
Have difficulty cutting with scissors			
Have a dominant hand			
Have difficulty matching, sorting or doing puzzles			
Social			
Avoids eye contact			
Plays and interacts with peers			
Is able learn new skills without excess effort or frustration			
Is frequently frustrated			
Have frequent mood changes			
Have difficulty with transitions or changes in routine			
Have tantrums, (frequency, duration and trigger)			
Is able to imitate expressions and movements			
Does not intrude on other children's space			
Sensory			
Appear to be irritated by certain fabrics or clothing?			
Dislike getting their hands dirty?			
Object to being touched?			
Child have difficulty getting to sleep? How many hours a night do they sleep?			
Overly sensitive to noise or distracted by noise?			
Fascinated by certain visual stimulii, i.e. Spinning objects, vertical or horizontal lines?			
Hesitate to climb on playground equipment?			
Seek lots of spinning, crashing, jumping ; i.e. on the go?			
Use inappropriate force, either too little or too much			
Have difficulty imitating motor actions, Pat-A-Cake or Simon Says?			
Infant Sensory			
Suck his/her thumb, until what age			
Colicky or fussy baby			
Able to self soothe			
Enjoy bouncing			
Become calmed by car rides or swings.			
Strongly dislike being on his/her stomach as an infant?			

What are your child's favorite activities?

What things does your child seem to fear or avoid, if any?

What are your child's greatest strengths?

Do you have any tips or strategies to suggest when working with your child?

Please list any questions or concerns that you would hope this screening/evaluation would answer?