TOTAL Kids PEDIATRIC THERAPY

Please check all areas of concern that you would like the OT to be aware of:

What are one or two things that you would like OT to focus on initially that would make the biggest difference in your child's/your family's life? :

Does your child participate well in his/her self-care routine (dressing, bathing, grooming, brushing teeth, toileting)? Please describe your concerns?:

How does your child tolerate various sensations in their environment? (Vision, hearing, touch, taste, smell, movement, balance). Please describe your concerns?:

Does your child display signs of overstimulation or under stimulation with various sensory input? (Vision, hearing, touch, taste, smell, movement, balance). Please describe their behavior.:

Does your child participate well in group activities or interactions with their peers or other adults? Please describe your concerns.:

Does your child experience difficulties with hand-eye coordination when using items (throwing/catching ball, guiding a pencil, placing items in a small hole, etc.)? Please describe your concerns.:

Does your child experience difficulties with how they use their hands and fingers to manage toys, toys, and utensils? Please describe your concerns.:

Does your child experience difficulties with perceiving his/her environment (recognizing shapes, locating specific objects, completing age-appropriate puzzles)? Please describe your concerns. :

Does your child experience difficulties with regulating his/her behavior or emotions throughout their day? Please describe your concerns.:

Is there any information that would be helpful for the OT to know? :