EDUCATIONAL HISTORY /SCHOOL / DAY CARE

Name of School / Day Care: _____ Telephone: _____

In your opinion, would the school/day care be willing to follow treatment for your child's difficulties? ____ Y ____N

Does your child receive 'Early childhood Intervention' services? __Y__N Type: _____ Does your child have? __**IFSP** __IEP

Provide a copy __Y__N Attends ____Preschool ____Daycare ____Primary School Frequency: _____

Therapy in public school __Y __N Type: _____ For: _____ Frequency of Service _____

Do you feel these services meet your child's needs? _____ Reasons: _____

OBSERVATIONS Please check all that apply.

Motor Control and Planning:

____ did not crawl before able to walk
____ falls frequently (over 8 mos.)
____ fatigues easily during physical activities
____ scared to try new motor activities
____ difficulty with small objects /fasteners
____ has loose grip on objects such as pencil / spoon OR grip is too tight
____ has difficulty with dressing and sequenced motor actions (skipping, buttoning, scissoring)
____ trips over or bumps into obstacles

Play / Interactions and Self-Regulation:

___ difficulty transitioning- between activities
___ is easily frustrated, likes to control activities and environment-, "runs the show"
___ difficulty separating from, parents, sitter,
___ responds to discipline / limit-setting
___ impatient-, has difficulty waiting for food or toy
____ has difficulty calming self
____ unable to interact with care-giver
____ avoids eye contact-, turns away from faces
____ prefers certain toys or objects
____ needs routine

Adaptive *Behaviors:* (please check all that apply)

___ walks without assistance ___ follows directions ___uses words or signs to communicate ___toilet trained ___ hearing impaired
___ can imitate modeled words or behaviors ___needs glasses/ visually impaired

Supervisor Needs:

___ 1 - 1 supervision at all times ___distant supervision or monitoring ___ can be left unattended for short time

***Behavioral* Concerns:** (please check all that apply)

___doesn't do what he/she is told
___temper tantrums
___hurts other people
___throws things
___is overactive
___separation anxiety
___does not interact
___difficulties playing with others
___eats non-edibles
___bites nails
___body rocking
___thumb sucking
___hand flapping
___repeats what others say
___insists on same way
___difficult to understand
___hurts self when frustrated
___accident prone
___difficulty paying attention
___frequent complaints
___potty trained but accidents at night
other: _____

Favorite Toys: _____

Favorite Activities: _____

Other Concerns: _____

Parent/ Caregiver Goals: _____