



Motor Skills Intake Form

Child's Name: _____ Date of Birth: _____

Please tell the approximate age your child achieved the following developmental milestones:

- _____ Sat alone
- _____ Crawled
- _____ Walked alone
- _____ Toilet training (day)
- _____ Toilet training (night)
- _____ Rode tricycle
- _____ Tied shoelaces
- _____ Feed self
- _____ Feed self with utensils
- _____ Drink from cup
- _____ Remove: shirt _____ pants _____
- _____ Put on: shirt _____ pants _____

Has your child ever had a physical or occupational therapy evaluation/ screening? Yes No
If yes, where and when?

What were you told?

Has your child ever had physical or occupational therapy? Yes No
If yes, where and when?

What was he/ she working on in therapy?

Check all that apply
Does your child ...

TACTILE (TOUCH)

- Dislike being held or cuddled?
- Constantly touch objects or intrude in others personal space?
- Seems easily irritated or enraged?
- Have a strong need to touch objects and people?
- Pinch, bite or otherwise hurt him/herself or others?
- Frequently bumps or pushes others?
- Doesn't cry when seriously hurt?
- Dislikes the feeling of fuzzy/furry clothing/textures?

- o Over or under dresses for the temperature?
- o Seem overly sensitive to rough food textures?
- o Dislike having hair washed/ cut or nails cut?
- o Dislike the feeling of sand, mud, and clay on hands/feet?
- o Often seems unaware of minor cuts, bruises, etc?
- o Seem unaware of food/liquid left on lips?
- o Tell what is in his/her hand without looking?

Comments:

VESTIBULAR (MOVEMENT)

- o Like rough housing, jumping, crashing games?
- o Like being tossed in the air?
- o Like fast spinning carnival rides?
- o Play on swings or slides?
- o Spin or whirls more than other children?
- o Get carsick easily?
- o Get nauseous and/or vomit easily?
- o Does your child...
- o Have fear in space (stairs, heights)?
- o Lose balance easily?
- o Walks on toe (not flat feet)?
- o Like being upside down (somersaults, hanging from legs)?
- o Prefer to be sedentary (on computer/ TV) than play outside?

Comments:

VISUAL

- o Have a diagnosed vision problem?
- o Have trouble tracking objects with eyes?
- o Avoid eye contact with others?
- o Have trouble copying words from the board?
- o Make reversals when copying or reading?
- o Have trouble discriminating shapes, colors correctly?
- o Squint often (when reading or outside in sunlight)?

Comments:

TASTE & SMELL

- o Chew on non-food items (pencils, shirt, hair)?
- o Demonstrate being an EXTREMELY picky eater?
- o Cough or gag on food?
- o Have trouble eating different textured foods?
- o Sensitive or insensitive to noxious smells/tastes?
- o Taste or smell objects when playing with them?

Comments:

AUDITORY (SOUND)

- o Have a diagnosed hearing problem?
- o Have frequent ear infections?
- o Show difficulty/bothered by loud sounds (school bells, sirens)?
- o Respond negatively to unexpected noises?

- o Bothered by background noises such as refrigerator, fluorescent light bulbs, fans, when trying to concentrate?
- o Fail to listen, or pay attention to what is said to him/her?
- o Like to play or make music at loud volumes?
- o Like to sing and/or dance to music?
- o Have difficulty if 2 or 3 steps instructions are given at once?
- o Talk excessively/ not wait their turn?

Comments:

MUSCLE TONE

- o Have any diagnosed muscle problems?
- o Slouch when sitting on floor/chair?
- o Get tired easily playing or writing?
- o Seem generally weak compared to other kids?

COORDINATION

- o Have difficulty with sequential tasks; dressing, buttoning, zipping?
- o Have difficulty playing on playground equipment?
- o Have difficulty learning to hold a pencil or crayon in a 3-point position?
- o Have poor ball skills for P.E. type activities?
- o Seem clumsy, awkward?
- o Bump into furniture or people a lot?
- o Consistently use a dominant hand?
If yes, which hand? Right Left
- o Have poor handwriting?
- o Have trouble using both hands together easily (opening milk carton, water bottle etc.)?
- o Enjoy sports, gym, etc?
- o Able to ride a bike (tricycle, big wheel)?
- o Able to tie shoelaces?

Comments:

BEHAVIOR/TEMPERAMENT

- o Quiet, calm, relaxed, patient?
- o Active, outgoing, enthusiastic?
- o Intense, demanding?
- o Seem hyperactive, in perpetual motion all the time?
- o Upset by transitions/unexpected changes?
- o Passive, quiet, withdrawn?
- o Rigid, set in his/her ways?
- o Regular sleep patterns?
- o Difficult to get to sleep?
- o Destructive with toys?
- o Short attention span?
- o Very cautious/ afraid to try new things?
- o Nearly impossible to take to the movies, church/temple or other settings that don't allow them to move around?
- o Jump off tall furniture, climbs trees without regard to safety
- o Have trouble keeping personal space neat/organized (desk,Room)?

Comments:

Please feel free to add any further information that you feel would assist us in learning more about your child such as your child's strengths as well as areas of difficulty (if not previously mentioned above).

Person completing form: _____
Relationship to child: _____