Initial Evaluation

Client Name:_____Date:_____

Children in family:_____ D.O.B._____

Parent/Guardian_____Birth/Adopted_____

Therapies_____

Present Concerns:_____

Hungry/Full?: _____

Chewing, Swallowing, Digestion_____

Bladder, Bowel Function:_____

Sleep:_____

Temperature Regulation:_____

Menstruation:_____

When and how did problem become apparent?

When client was a baby, before they learned to walk, where did they spend most of their time when they were awake? (walker, jumper being held, etc.

_____

_____

Client Name:_____Date:_____

MOBILITY: **R L M**

Crawl:

Creep:

Walk:

Run:

Skip:

Hop: R L

LANGUAGE:

MANUAL: **R L M**

Cortical Opposition:

Supination/Pronation:

near

VISUAL: **R L M**

far

Pupils: **R L M**

Horizontal:

Vertical:

Convergence: ⊕ ⊕

AUDITORY: **R L M**

TACTILE: **R L M**

Touch: Likes soft brush – Yes No

Pain: Reacts to hard brush Yes No

Position Sense:

Point Discrimination: R: H_____A_____U_____Face:_____

L:_H____A_____U_____Face:_____

Stereognosis:

Babinski:

Crawl _____

Creep_____

Firm comp._____

Firm brush/textures ____X 15sec

Bony Joint _____X 30 sec.

Light touch _____X 15 sec soft brush/textures

Trigeminal/Nuk ___15 sec

Vestibular 8 x 15 sec.

Masking _____

Patterns: _____x_____day

_____ X____ day

_____ X____ day

_____ X____ day

_____ X____ day

_____ X____ day

	VISUAL	AUDITORY	TACTILE	MOBILITY	LANGUAGE	HAND FUNCTION
CORTEX						
CORTEX						
CORTEX						
CORTEX						
MIDBRAIN						
PONS						
EDULLA & CORD						

TLR:_____ Moro:_____

STNR:_____ FPR:_____

Landau:_____

Gallant:_____

ATNR:_____