Initial Assessment

Today's Date _____

New Assessment Form

Client name _____ Gender ____Date of Birth_____

Siblings and birth order _____

Phone #1 _____ Cell _____ Email _____

Street Address _____

Parent/Guardian _____ Handedness _____

Parent/Guardian _____ Handedness _____

Diagnosis and medications _____

Present concerns:

Pregnancy, birth and family history:

Illnesses and Injuries:

Development: Sat up _____ Crawled _____ Crept _____

Walked _____ Talked _____ Vaccine Reaction? _____

_____

Mobility

- Crawl
- Creep
- Walk
- Run
- Skip
- Hop

Language

Manual

- Cortical Opposition
- Supination/pronation

Visual

- Pupils
- Horizontal
- Vertical
- Convergence

Auditory

Tactile

- Touch
- Pain
- Position Sense
- Point Discrimination
- Stereognosis

Program