

Initial Evaluation

Today's Date _____

New Evaluation 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