# Initial Assessment

Today's Date _____

Client Name _____ Gender ___ Date of Birth _____

Siblings and Birth Order _____

Phone #1 _____ Cell _____ Email _____

Street Address _____

Parent _____ Handedness _____

Parent _____ Handedness _____

Diagnosis and Physician _____

Therapies _____

Present Concerns:

Pregnancy, Birth, and Family History:

Illnesses and Injuries:

Development: Sat Up _____ Crawled _____ Crept _____
Walked _____ Talked _____ Vaccine Reaction? _____
Hungry/Full _____
Digestion/Swallowing/Chewing _____
Bladder/Bowel Function _____
Sleep _____ Temperature Regulation _____

Mobility R. L. M.

Crawl

Creep

Walk

Run

Skip

Hop R. L.

Language

Manual R. L. M.

Cortical Opposition

Supination/pronation

Visual Near: R. L. M.

Far: R. L. M.

Pupils

Horizontal

Vertical

Convergence  

Auditory R. L. M.

Tactile R. L. M.

Touch: Hypersensitive?

Pain: Ignores/Doesn't feel?

Position Sense

Point Discrimination: R: H _____ A _____ UA _____ Face _____
L: H _____ A _____ UA _____ Face _____

Stereognosis

Babinski: R _____ L _____

Program:

Links sent to client:

Materials and supplies recommended to clients: