PT & OT
2 years & Under

TERRIOKIDS

Physcial, Occupational & Speech Therapy

Questionnaire

Client Name: _____ Diagnosis: _____
Date: _____ Client age: _____

Does client have troubles: *(Please check all that apply)*

- ☐ Grasping objects ☐ One hand only ☐ Both hands
- ☐ Holding objects ☐ One hand only ☐ Both hands
- ☐ Releasing objects ☐ One hand only ☐ Both hands
- ☐ Tracking visually ☐ To the right ☐ To the left ☐ Both directions
- ☐ Extending arms to obtain an object ☐ One side only ☐ Both sides

Comments: _____
_____

- ☐ Maintaining Head Control
- ☐ Rolling from stomach to back ☐ One direction only ☐ Both directions
- ☐ Rolling from back to stomach
- ☐ Holding head up while on stomach
- ☐ Maintaining sitting
- ☐ Crawling
- ☐ Pulling up to stand
- ☐ Sanding Independently
- ☐ Walking

Comments: _____
_____

Please list any additional concerns you might have:_____
_____
_____
_____
_____

Please List Goals and Priorities:
_____
_____
_____
_____
_____
_____

Does client wear: Glasses ☐ Yes ☐ No, Hearing Aids ☐ Yes ☐ No