

## Questionnaire

Client Name: Date:	Diagnosis:
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 ☐ ☐ ☐ Extending arms to obtain an object ☐ One side only	
Comments:	
<ul> <li>☐ Maintaining Head Control</li> <li>☐ Rolling from stomach to back</li> <li>☐ Rolling from back to stomach</li> <li>☐ Holding head up while on stomach</li> <li>☐ Maintaining sitting</li> <li>☐ Crawling</li> <li>☐ Pulling up to stand</li> <li>☐ Sanding Independently</li> <li>☐ Walking</li> </ul>	only □ Both directions
Comments:	
Please list any additional concerns you might have:	
Please List Goals and Priorities:	

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