Jones
THERAPY SERVICES
615-614-8833 jonestherapyservices.com

Child's Full Name: _____ Date of Birth: _____/_____/_____

Occupational Therapy Information

Please describe how much help, if any, your child requires with self-care skills (dressing, bathing, feeding).

_____

_____

_____

Please describe your child's fine motor coordination and upper body strength. (Fine motor skills involve the small muscles of the body that enable such functions as writing, grasping small objects, and fastening clothing. They involve strength, fine motor control, and dexterity.)

_____

_____

_____

Has your child developed a hand preference? Yes No If yes, Right Left

Please describe any sensory issues/concerns (sensitivity to touch, smell, sound, gets dizzy and/or tires easily, avoids/craves messy activities). _____

_____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

Additional Comments or Concerns

_____

_____

_____