PEDIATRIC DISCOVERY/ASSESSMENT INTAKE FORM

Part 2 – Beyond Discovery

SENSORIMOTOR HISTORY

TOUCH

My child:	Becomes upset when their hair is cut	Yes	No
	Dislikes having their hair combed or washed	Yes	No
	Dislikes when their hands are messy	Yes	No
	Shows decreased tolerance for having their nails trimmed	Yes	No
	Dislikes the feeling of sand or grass	Yes	No
	Avoids handling certain textures or being barefoot on different surfaces (e.g., grass, sand, carpet, tile flooring, etc.)	Yes	No
	Becomes upset when someone sits too close or brushes against them	Yes	No
	Constantly touches or taps objects or people	Yes	No
	Seem unaware of food or liquid left on their lips, mouth or face	Yes	No

	Sit too close to other people or lies on top of them	Yes	No
	Pinches, bites, hits, or otherwise hurts themselves	Yes	No
	Frequently bump or push others	Yes	No
	Dislikes crowded places or close spaces	Yes	No
	Doesn't cry when seriously hurt	Yes	No
Comments:			

MOVEMENT

Does your child:	Like rough housing, horse play, rough and tumble	Yes	No
	Like being tossed in the air	Yes	No
	Like to turn in circles	Yes	No
	Like the swings and slide at the park	Yes	No
	Like to jump	Yes	No
	Have difficulty with sitting still	Yes	No
	Like to crash to the floor or on furniture	Yes	No
	Get carsick easily	Yes	No
	Get nauseous and/or vomit easily	Yes	No
	Have fear of stairs, heights, etc.	Yes	No
	Lose their balance easily	Yes	No
	Walk on their toes	Yes	No
	Like being upside down (somersaults etc.)	Yes	No
	Prefer to be sedentary or still (computer or television) over playing outside	Yes	No
Comments:			

VISUAL

Does your child:	Have a diagnosed vision problem? If so, please describe.	Yes	No
	Have trouble following or tracking with their eyes	Yes	No
	Lose balance or struggle with walking when there are different lines or levels on the floor		
	Avoid eye contact with others	Yes	No
	Have trouble copying from the board	Yes	No
	Dislike having eyes covered	Yes	No
	Make reversals when copying letters	Yes	No
	Have trouble discriminating shapes, colors correctly	Yes	No
	Squint often (when reading or outside in the sun)	Yes	No
	Prefer to be in the dark	Yes	No

	Like to watch things that spin	Yes	No
	Spin objects or toys such as wheels on cars, etc.	Yes	No
Comments:			

TASTE & SMELL

My child:	Chews on or eats non-food items	Yes	No
	Is an EXTREMELY picky eater	Yes	No
	Has trouble eating different textured foods	Yes	No
	Can be sensitive/ insensitive to noxious smells/tastes	Yes	No
	Tastes or smells objects when playing with them	Yes	No
	Prefers spicy, sour, bitter or strong food flavors	Yes	No
Comments:			

SOUND

Does your child:	Have a diagnosed hearing problem? Please describe.	Yes	No
	Have PE tubes in their ears	Yes	No
	Have frequent ear infections	Yes	No
	Show difficulty or is bothered by loud noises	Yes	No
	Respond negatively to loud or unexpected noises	Yes	No
	Shows heightened awareness to background noise such as the refrigerator, fluorescent light bulbs, fans, etc.	Yes	No
	Ignore you or fail to listen when you're speaking to them	Yes	No
	Like to play music at loud volumes	Yes	No
	Like to sing or dance to music	Yes	No
	Have difficulty with following directions with more than one step	Yes	No
	Talk excessively or fail to wait for their turn	Yes	No
	Have a delay in speech development	Yes	No

Comments:

BEHAVIOR/TEMPERAMENT

Is your child:	Quiet, calm, relaxed, patient	Yes	No
	Active, outgoing, enthusiastic	Yes	No
	Intense, demanding	Yes	No
	Seem hyperactive, always in motion	Yes	No
	Upset by changes to routine, transitions	Yes	No
	Passive, quiet, withdrawn	Yes	No
	Rigid, set in his/her ways	Yes	No
	Regular sleep patterns	Yes	No
	Difficult to get to sleep	Yes	No
	Destructive with toys	Yes	No
	Short attention span	Yes	No
	Very cautious/afraid to try new things	Yes	No
	Nearly impossible to take to the movies, restaurants, church/temple or other settings that don't allow them to move around	Yes	No
	Jump off tall furniture, take climbing risk (A risk taker with limited awareness of consequences or safety?)	Yes	No
	Having trouble keeping their personal space neat/organized (desk, drawers, room)	Yes	No
	Readily engaging in play or interactions with other children		
	Preferring to play on their own		

Comments:

Safety Issues:

My Child:

Stays with me when we are walking on the sidewalk or out in public spaces (e.g., the mall, parkades, movie theatre, etc.).	**Yes**	**No**
Responds to their name when called or redirected	**Yes**	**No**
Slows down or stops when warned	**Yes**	**No**
Shows an awareness of safety/concern for themselves and others	**Yes**	**No**

Please use this space to provide us with any additional information that you feel will help us during our assessment and treatment process:

THANK YOU FOR TAKING THE TIME TO PROVIDE THIS INFORMATION.