**FOR TEACHER, OT, or PT TO COMPLETE**

**Child's Name**________________________

## School-Age Checklist for Occupational Therapy
## Ages 5 - 12 years

Dear Colleague: Thank you for completing the following checklist. It will help us to determine the most appropriate evaluation for this child. We welcome your observations and insights. In addition to filling out this form, please feel free to call and ask to speak to our therapist who is evaluating this child. Thank you for returning this form to us.

Sincerely, The Staff of OTA

**Check three (3) areas of difficulty; underline specific problems, star (*) prominent difficulties.** If child has overall difficulty in one category, or shows several items in three or more categories, this may indicate a need for an occupational therapy evaluation.

| *Does the child exhibit the following behaviors?* | Frequently | Sometimes | Never | Comments |
|---|---|---|---|---|
| **GROSS MOTOR SKILLS** | | | | |
| 1. Seems weaker or tires more easily than other children. | | | | |
| 2. Difficulty with hopping, jumping, skipping, or running compared to others his/her age. | | | | |
| 3. Appears clumsy or seems not to know how to move body, bumps into things or has difficulty force. | | | | |
| 4. Hesitates to climb or play on playground equipment. | | | | |
| 5. Reluctant to participate in sports or physical activity. | | | | |
| 6. Seems to have difficulty learning new motor tasks. | | | | |
| **FINE MOTOR SKILLS** | | | | |
| 1. Poor desk posture (e.g., slumps, leans on arm, head too close to work). | | | | |
| 2. Difficulty drawing or writing. | | | | |
| 3. Poor pencil grasp. | | | | |
| 4. Fatigues quickly during writing or other pencil and paper tasks. | | | | |
| 5. Hand dominance not well established (after age six). | | | | |
| 6. Difficulty with clothing fasteners, shoe tying, drink containers, etc. | | | | |
| **TOUCH** | | | | |
| 1. Seems overly sensitive to touch. | | | | |
| 2. Avoids putting hands in messy substances. | | | | |
| 3. Has trouble remaining in busy or group situations (e.g., cafeteria, circle time). | | | | |
| 4. Has trouble keeping hands to self, will poke or push others. | | | | |
| 5. Reacts to pain differently than peers. | | | | |
| 6. Needs to touch things constantly. | | | | |
| **VISUAL PERCEPTION** | | | | |
| 1. Difficulty lining up math problems. | | | | |
| 2. Spacing and size of letters and words is inconsistent. | | | | |
| 3. Difficulty copying from blackboard. | | | | |
| 4. Difficulty keeping place while reading. | | | | |
| 5. Reversals in words or letters after first grade. | | | | |

| | Frequently | Sometimes | Never | Comments |
|---|---|---|---|---|
| **AUDITORY LANGUAGE** | | | | |
| 1. Overly sensitive to loud noises (e.g., bells, toilet flush). | | | | |
| 2. Difficulty following directions. | | | | |
| 3. Easily distracted by sounds; seeming to hear sounds that go unnoticed by others. | | | | |
| **BEHAVIOR AND ORGANIZATION** | | | | |
| 1. Does not accept changes in routine easily. | | | | |
| 2. Becomes easily frustrated. | | | | |
| 3. Difficulty getting along with other children. | | | | |
| 4. Marked mood variations, tendency towards outbursts or tantrums. | | | | |
| (Please note what events trigger these outbursts) | | | | |
| 5. Has trouble making needs known in appropriate manner. | | | | |
| 6. In constant motion often squirms, bounces, rocks, etc. | | | | |

**ACADEMIC DIFFICULTIES**

_______ Reading
_______ Math
_______ Spelling
_______ Slow writer
_______ Poorly organized
_______ Finishing tasks
_______ Remembering information
_______ Short attention span

**When does the child seem to perform at his or her best?**

_____ one on one ______ small group ______ whole class ______ indoors _____ outdoors

**At what time of day does the child perform best?** _______________________

**What are the biggest factors that impede the child's performance?**

**Are there any strategies that help this child perform better?**

**How concerned are you about the above checked problems?**

**Not concerned ____ Slightly ____ Moderately ____ Very ____**

**Child's Name: ____________________ Birth Date: _________ Age: ________ Date Completed: ___________**

**Name of Case Manager/Therapist/Teacher: _____________________________**

**Signature of person completing form: _________________________________**

**Phone(s): H: ____________ W: _____________Email: _____________________________________________**

**PLEASE ATTACH QUESTIONS AND COMMENTS ON A SEPARATE PAGE.**