INTEGRATED CHILDREN'S THERAPIES, INC.

where children make connections

DEVELOPMENTAL/SENSORY HISTORY

Ages Adolescents to Adults

This history may appear to be quite long, however, a number of the questions require checking off responses, which can be done quickly. This information is very useful in gaining a clear understanding of your strengths and concerns. We appreciate your time.

Person Completing History: ☐Mother ☐ Father ☐ Self ☐ Other (specify) _____

General Information:

Full Name:_____ Birth Date:_____

Address:_____ Gender: ☐male ☐ female

_____ Phone #:_____

Client's Race: ☐ Caucasian ☐ African Am. ☐Hispanic ☐Asian ☐Native Am. ☐Other (specify) _____

Client is: ☐married ☐separated ☐divorced ☐widowed ☐single ☐other (specify) _____

Parent's Name:_____ Relation to Client:_____

Occupation:_____ Employer:_____

Phone #:_____

Highest education completed: ☐less than high school ☐high school grad ☐some college/associates ☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Parent's Name:_____ Relation to Child: _____

Occupation:_____ Employer:_____

Phone #:_____

Highest education completed: ☐less than high school ☐high school grad ☐some college/associates ☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Emergency Contact Person:_____

(Name) (Relationship) (Phone #)

Referred by (name, address, profession):_____

What do you hope to gain from this evaluation and/or treatment? _____

_____

_____

Handedness (hand you use to write or eat): ☐ Right ☐ Left ☐ Mixed dominance

Medical Information:

Client's Physician and other Professionals: (continue on back of page if needed)

Physician: _____ Address: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Medical Diagnosis:

☐ ADD/ADHD ☐ Autism ☐Pervasive Developmental Disorder (PDD) ☐Cognitive Delay

☐Down Syndrome ☐Fragile X Syndrome ☐ Anxiety Disorder or Mood Disorder, specify: _____

☐Tourette's Syndrome ☐Non-Verbal Learning Disability ☐Emotional Disorder, specify: _____

☐Learning Disabilities, specify if possible: _____

☐ Other, specify: _____

Have you received previous evaluation and/or treatment by an occupational therapist? _____

If yes, when and where: _____

Have you had a vision test recently? ☐Yes ☐No If yes, when? _____

Are you color blind? ☐Yes ☐No

Have you had a hearing test recently? ☐Yes ☐No If yes, when? _____

What were the results of hearing and vision tests? _____

_____

Have you had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses: _____

Congenital abnormalities: _____

Surgery: _____

Serious injury: _____

Casts or braces: _____

Ear infections: _____

Tubes in ears: _____

Allergies: _____

Seizures: _____

Other: _____

List any medications you are **currently** taking: _____

_____

_____

Are there any medical precautions the therapist should be aware of when working with you?_____

_____

Have you received other evaluations or treatment (school, psychological, private therapist or clinic, neurology, nutritionist, GI consult, allergist, etc.)? If so, what type, when, and by whom?

Type Eval. Date Professional's Name Dates of therapy

_____

_____

_____

The following questions are regarding your birth and childhood history. While you may not have access to much of this information, please answer as completely as possible.

Childhood Developmental History:

Child birth: Were you a:

1) full term baby? ☐Yes ☐No If premature, number of weeks: _____

2) breech (feet first) ☐Yes ☐No

3) Did you require intensive care hospitalization? ☐Yes ☐No If yes, for how long? _____

As a child, did you:

1) have feeding problems (i.e. trouble using bottle, learning to use spoon, drinking from cup, etc.) ☐Yes ☐No

If yes, describe:_____

2) have sleeping problems? ☐Yes ☐No If yes, describe:_____

_____

Developmental Milestones (Mark as late (L), early (E) or average (A), if known and comment on anything unusual):

Roll ☐ Walk ☐ Crawl ☐ Sit alone ☐ Say words ☐ Say sentences ☐

Drink from a cup ☐ Chew solid food ☐

Comments: _____

_____

Did you have trouble learning bowel and bladder control? ☐Yes ☐No

Cognitive/Attention Skills

Do/did you have difficulty in any of the following? (Check those that apply)

Reading ☐ Math ☐ Spelling ☐ Handwriting ☐ Finishing tasks ☐ Organizing work ☐

Following directions ☐ Paying attention ☐ Remembering information ☐ Restlessness ☐

Other _____

Do/Did you receive any special education services: ☐Yes ☐No If yes, describe:_____

_____

Current and Past Sensory History:

Please check the appropriate area, comment as desired, and cross out any parts of questions which do not fit. This information will let us know if things were problems in the past, but are not now. Please refer to the scale below when answering.

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Visual Spatial Processing

Did/Do you:	**Past**					**Present**					**Examples and/or Comments**
Modulation											
1) blink at bright lights or feel irritated or fatigued by them?	5	4	3	2	1	5	4	3	2	1	
2) become easily visually distracted?	5	4	3	2	1	5	4	3	2	1	
3) avoid or feel uncomfortable with eye contact?	5	4	3	2	1	5	4	3	2	1	
Discrimination											
4) have difficulty finding items on a grocery shelf?	5	4	3	2	1	5	4	3	2	1	
5) tend to write some numbers and letters backwards?	5	4	3	2	1	5	4	3	2	1	
6) frustrated doing puzzles due to the visual demands?	5	4	3	2	1	5	4	3	2	1	
7) have difficulty interpreting drawings in comics or cartoons?	5	4	3	2	1	5	4	3	2	1	
8) have difficulty matching socks?	5	4	3	2	1	5	4	3	2	1	
9) have difficulty finding a familiar face in a crowd?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Visual Spatial Processing (continued)

Did/Do you:	Past					Present					Examples and/or Comments
10) have difficulty figuring out how to arrange furniture in a room?	5	4	3	2	1	5	4	3	2	1	
11) have difficulty reading and following traffic signs while driving?	5	4	3	2	1	5	4	3	2	1	
12) see double?	5	4	3	2	1	5	4	3	2	1	
13) have trouble following objects with eyes?	5	4	3	2	1	5	4	3	2	1	
14) have difficulty locating the appropriate aisle in a store?	5	4	3	2	1	5	4	3	2	1	

Auditory and Language Processing

Did/Do you:	Past					Present					Examples and/or Comments
Modulation											
1) seem overly sensitive to sounds?	5	4	3	2	1	5	4	3	2	1	
2) become distracted by noise more than other people?	5	4	3	2	1	5	4	3	2	1	
3) become distracted by background noises such as refrigerator, lights or fans?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Auditory and Language Processing (continued)

Discrimination											
Did/Do you:	**Past**					**Present**					**Examples and/or Comments**
4) have difficulty with listening when background noise is present in a movie theater or large gathering.?	5	4	3	2	1	5	4	3	2	1	
5) have difficulty understanding the words to a song when listening on a radio?	5	4	3	2	1	5	4	3	2	1	
6) seem to have trouble remembering or understanding what is said?	5	4	3	2	1	5	4	3	2	1	
7) have speech or articulation difficulties?	5	4	3	2	1	5	4	3	2	1	
8) have trouble finding the language to express what you want?	5	4	3	2	1	5	4	3	2	1	

Movement

Did/Do you:	**Past**					**Present**					**Examples and/or Comments**
Modulation											
1) dislike going on swings?	5	4	3	2	1	5	4	3	2	1	
2) avoid fast carnival rides that spin or go up and down?	5	4	3	2	1	5	4	3	2	1	
3) avoid roller coasters?	5	4	3	2	1	5	4	3	2	1	
4) dislike flying in airplanes?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Movement (continued)

Did/Do you:	Past					Present					Examples and/or Comments
5) become motion sick in cars, airplanes, or boats?	5	4	3	2	1	5	4	3	2	1	
6) become upset when head is tilted backwards or forwards as in hair washing?	5	4	3	2	1	5	4	3	2	1	
7) dislike roughhousing?	5	4	3	2	1	5	4	3	2	1	
8) rock yourself when seated in a regular chair?	5	4	3	2	1	5	4	3	2	1	
9) enjoy jumping or jogging a lot?	5	4	3	2	1	5	4	3	2	1	
10) feel uncomfortable if not in front seat while riding in a car?	5	4	3	2	1	5	4	3	2	1	
11) dislike elevators or escalators?	5	4	3	2	1	5	4	3	2	1	
Discrimination											
12) have difficulty learning to ride a bike?	5	4	3	2	1	5	4	3	2	1	
13) have difficulty merging while driving onto a freeway?	5	4	3	2	1	5	4	3	2	1	
14) have poor balance?	5	4	3	2	1	5	4	3	2	1	
15) hesitate or avoid climbing ladders?	5	4	3	2	1	5	4	3	2	1	
16) feel fearful of catching balls?	5	4	3	2	1	5	4	3	2	1	
17) walk on your toes frequently?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Movement (continued)

Did/Do you:	Past					Present					Examples and/or Comments
18) hesitate going up stairs?	5	4	3	2	1	5	4	3	2	1	
19) hesitate going down stairs?	5	4	3	2	1	5	4	3	2	1	
20) often lose your balance when a bus, car or subway stops quickly?	5	4	3	2	1	5	4	3	2	1	
21) have difficulty driving a car?	5	4	3	2	1	5	4	3	2	1	
22) dislike having eyes covered?	5	4	3	2	1	5	4	3	2	1	
23) experience things as moving which are not moving?	5	4	3	2	1	5	4	3	2	1	
24) have difficulty traveling through a tunnel without feeling uncomfortable?	5	4	3	2	1	5	4	3	2	1	
25) have difficulty finding a seat in a dark movie theater?	5	4	3	2	1	5	4	3	2	1	
26) have difficulty reproducing a rhythm with your hands?	5	4	3	2	1	5	4	3	2	1	
27) get lost easily in new or familiar places.	5	4	3	2	1	5	4	3	2	1	
28) have trouble discriminating fast and slow motion?	5	4	3	2	1	5	4	3	2	1	
29) shake/rock/bang your head?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Taste and Smell

Did/Do you:	Past					Present					Examples and/or Comments
Modulation											
1) react negatively or seem overly sensitive to odors (i.e., perfume, foods, cleaners)?	5	4	3	2	1	5	4	3	2	1	
2) react negatively to the taste of foods?	5	4	3	2	1	5	4	3	2	1	
3) find it uncomfortable to eat at restaurants because of food or smells?	5	4	3	2	1	5	4	3	2	1	
Modulation/Discrimination											
4)react negatively to the texture of foods?	5	4	3	2	1	5	4	3	2	1	
5) dislike or have more difficulty eating textured than smooth foods?	5	4	3	2	1	5	4	3	2	1	
6) dislike or have difficulty eating smooth foods with a few lumps (e.g., soup)?	5	4	3	2	1	5	4	3	2	1	
7) lick, suck or chew on non-food items? (e.g., hair, pencils)	5	4	3	2	1	5	4	3	2	1	
8) tend to explore with smells and/ or deliberately smell objects?	5	4	3	2	1	5	4	3	2	1	
9) feel as though all food taste the same?	5	4	3	2	1	5	4	3	2	1	
10) prefer crunchy textured foods?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Taste and Smell (continued)

Did/Do you:	Past					Present					Examples and/or Comments
11) eat foods that are:											
a) sweet	5	4	3	2	1	5	4	3	2	1	
b) sour	5	4	3	2	1	5	4	3	2	1	
c) salty	5	4	3	2	1	5	4	3	2	1	
d) spicy	5	4	3	2	1	5	4	3	2	1	
e) bitter	5	4	3	2	1	5	4	3	2	1	

Touch (Tactile processing)

Did/Do you:	Past					Present					Examples and/or Comments
Modulation											
1) seem excessively ticklish?	5	4	3	2	1	5	4	3	2	1	
2) become irritated by tags in the back of shirts?	5	4	3	2	1	5	4	3	2	1	
3) prefer to touch rather than be touched?	5	4	3	2	1	5	4	3	2	1	
4) dislike having your hair cut or shampooed?	5	4	3	2	1	5	4	3	2	1	
5) dislike having your fingernails or toenails cut?	5	4	3	2	1	5	4	3	2	1	
6) do not like petting animals due to feeling of fur?	5	4	3	2	1	5	4	3	2	1	
7) feel bothered by clothes (e.g. sock seams or turtlenecks).	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (continued)

Did/Do you:	Past					Present					Examples and/or Comments
8) tend to prefer long sleeves and pants regardless of weather?	5	4	3	2	1	5	4	3	2	1	
9) dislike cloth of certain textures?	5	4	3	2	1	5	4	3	2	1	
10) avoid handling messy things or getting hands dirty?	5	4	3	2	1	5	4	3	2	1	
11) tend to be more sensitive to pain than others?	5	4	3	2	1	5	4	3	2	1	
12) become especially bothered by small cuts?	5	4	3	2	1	5	4	3	2	1	
13) notice and/or irritated by bumps on the bed sheets?	5	4	3	2	1	5	4	3	2	1	
14) over or under dress for the temperature?	5	4	3	2	1	5	4	3	2	1	
15) strongly dislike showers?	5	4	3	2	1	5	4	3	2	1	
16) become irritated when splashed with water?	5	4	3	2	1	5	4	3	2	1	
17) seem overly sensitive to food or water temperature?	5	4	3	2	1	5	4	3	2	1	
18) crave being held or cuddled?	5	4	3	2	1	5	4	3	2	1	
19) dislike light touch from other people?	5	4	3	2	1	5	4	3	2	1	
20) become very angry/annoyed when touched or bumped unexpectedly?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (continued)

Did/Do you:	**Past**					**Present**					**Examples and/or Comments**
21) dislike having arms or back stroked?	5	4	3	2	1	5	4	3	2	1	
22) dislike water running onto face in shower?	5	4	3	2	1	5	4	3	2	1	
23) dislike going barefoot?	5	4	3	2	1	5	4	3	2	1	
24) dislike shaving?	5	4	3	2	1	5	4	3	2	1	
Modulation/Discrimination											
25) tend to remove shoes whenever possible?	5	4	3	2	1	5	4	3	2	1	
26) mouth objects or clothing frequently?	5	4	3	2	1	5	4	3	2	1	
27) tend not to feel pain as much as others?	5	4	3	2	1	5	4	3	2	1	
28) seem oblivious to bruises and heavy falls?	5	4	3	2	1	5	4	3	2	1	
29) tend to examine objects by touching thoroughly with hands?	5	4	3	2	1	5	4	3	2	1	
30) have difficulty finding objects in your pocket or purse without looking?	5	4	3	2	1	5	4	3	2	1	
31) have difficulty applying shaving cream thoroughly to face or legs?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (continued)

Did/Do you:	Past					Present					Examples and/or Comments
32) have difficulty licking an ice cream cone?	5	4	3	2	1	5	4	3	2	1	
33) have difficulty recognizing food stuck on face/need to blow nose?	5	4	3	2	1	5	4	3	2	1	
35) bothered by people sitting/standing too close to you (e.g., theatres, parties)	5	4	3	2	1	5	4	3	2	1	

Proprioceptive Processing and Motor Skills

Did/Do you:	Past					Present					Examples and/or Comments
Proprioception											
1) bump into things frequently?	5	4	3	2	1	5	4	3	2	1	
2) over or underestimate amount of force needed for a task?	5	4	3	2	1	5	4	3	2	1	
3) seem shaky when doing fine motor tasks?	5	4	3	2	1	5	4	3	2	1	
4) frequently grasp objects very tightly?	5	4	3	2	1	5	4	3	2	1	
5) tend to break many objects?	5	4	3	2	1	5	4	3	2	1	
6) drop things easily?	5	4	3	2	1	5	4	3	2	1	
7) tend to eat in a sloppy manner?	5	4	3	2	1	5	4	3	2	1	
8) frequently spill liquids?	5	4	3	2	1	5	4	3	2	1	
9) have trouble chewing?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Proprioceptive Processing and Motor Skills (continue)

Did/Do you:	Past					Present					Examples and/or Comments
Proprioception											
10) think of yourself as clumsy?	5	4	3	2	1	5	4	3	2	1	
11) find physical activity organizing when overloaded or irritated?	5	4	3	2	1	5	4	3	2	1	
12) misunderstand meaning of words in relation to movement or body position (e.g., up, down, behind)?	5	4	3	2	1	5	4	3	2	1	
Posture/Muscle Tone-Strength											
13) grimace or move tongue while doing fine motor tasks?	5	4	3	2	1	5	4	3	2	1	
14) tire easily with physical activity or handwriting?	5	4	3	2	1	5	4	3	2	1	
15) tend to move in and out of chair while eating or doing work at a table?	5	4	3	2	1	5	4	3	2	1	
16) prefer to stand while working?	5	4	3	2	1	5	4	3	2	1	
17) have flat feet?	5	4	3	2	1	5	4	3	2	1	
18) slump while sitting?	5	4	3	2	1	5	4	3	2	1	
19) keep your mouth open?	5	4	3	2	1	5	4	3	2	1	
20) chew with your mouth open?	5	4	3	2	1	5	4	3	2	1	
21) hold a pencil differently than most people?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Proprioceptive Processing and Motor Skills (continue)

Did/Do you:	Past					Present					Examples and/or Comments
22) experience fatigue in hand with writing?	5	4	3	2	1	5	4	3	2	1	
23) can you sit in class or at a business meeting without moving excessively in your chair?	5	4	3	2	1	5	4	3	2	1	
Motor Planning											
24) have difficulty with motor tasks that have several steps?	5	4	3	2	1	5	4	3	2	1	
25) have poor handwriting?	5	4	3	2	1	5	4	3	2	1	
26) have difficulty figuring out how to plan a driving route to a new place?	5	4	3	2	1	5	4	3	2	1	
27) find small manipulative activities difficult?	5	4	3	2	1	5	4	3	2	1	
28) avoid fine motor activities?	5	4	3	2	1	5	4	3	2	1	
29) have difficulty following the steps of a recipe	5	4	3	2	1	5	4	3	2	1	
30) take a long time to do most motor tasks (e.g. dressing)?	5	4	3	2	1	5	4	3	2	1	
31) have difficulty planning a dinner, including setting the table, organizing timing of meals, etc.?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Proprioceptive Processing and Motor Skills (continued)

Did/Do you:	Past					Present					Examples and/or Comments
32) reluctant to participate in or dislike sports or games?	5	4	3	2	1	5	4	3	2	1	
33) tend to be slow in dressing?	5	4	3	2	1	5	4	3	2	1	
34) have difficulty learning exercise steps or routines?	5	4	3	2	1	5	4	3	2	1	
35) have difficulty reproducing a rhythm with your hands?	5	4	3	2	1	5	4	3	2	1	

Social/Emotional

Did/Do you:	Past					Present					Examples and/or Comments
1) make friends easily?	5	4	3	2	1	5	4	3	2	1	
2) tend to prefer to be alone?	5	4	3	2	1	5	4	3	2	1	
3) have a strong desire for sameness and routine?	5	4	3	2	1	5	4	3	2	1	
4) seem sensitive to criticism?	5	4	3	2	1	5	4	3	2	1	
5) lack self confidence?	5	4	3	2	1	5	4	3	2	1	
6) have strong outbursts of anger?	5	4	3	2	1	5	4	3	2	1	
7) have trouble getting along with others?	5	4	3	2	1	5	4	3	2	1	
8) tend to be active and/or aggressive?	5	4	3	2	1	5	4	3	2	1	
9) tend to be quiet and withdrawn?	5	4	3	2	1	5	4	3	2	1	
10) tend to lack carefulness?	5	4	3	2	1	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Social/Emotional

Did/Do you:	Past					Present					Examples and/or Comments
11) tend to be impulsive?	5	4	3	2	1	5	4	3	2	1	
12) tend to be easily frustrated?	5	4	3	2	1	5	4	3	2	1	
13) tend to be relaxed and patient?	5	4	3	2	1	5	4	3	2	1	
14) tend to be constantly "on the go"?	5	4	3	2	1	5	4	3	2	1	
15) tend to be most comfortable in routines?	5	4	3	2	1	5	4	3	2	1	
16) feel discouraged or depressed?	5	4	3	2	1	5	4	3	2	1	
17) have difficulty separating from parents or other loved ones?	5	4	3	2	1	5	4	3	2	1	
18) have fears of leaving your home on a daily basis?	5	4	3	2	1	5	4	3	2	1	
19) have panic attacks?	5	4	3	2	1	5	4	3	2	1	
20) have anxiety attacks?	5	4	3	2	1	5	4	3	2	1	

1) Do you have specific fears? ☐Yes ☐No If yes, please describe: _____

_____

_____

2) Are you concerned you may have medical/psychological problems? ☐Yes ☐No If yes, please describe:____

_____

_____

General State of Arousal:

Please share your thoughts on each of the following as they pertain to you:

Activity level:_____

_____

Attention Span:_____

_____

What do you do to help yourself pay attention?_____

_____

Stress Level:_____

_____

What do you do to help yourself calm down?_____

_____

Body temperature regulation (e.g., overheat easily): _____

_____

Sleep Patterns:

Do you:

1) have regular sleep patterns? ☐Yes ☐No If no, please describe: _____

_____

2) wake frequently during the night? ☐Yes ☐No If yes, please describe: _____

_____

3) tend to be an early riser, up and on the go? ☐Yes ☐No

4) have difficulty falling asleep? ☐Yes ☐No

5) What kinds of things do you do to help you wake up? _____

_____

6) What kinds of things do you do to help yourself fall asleep? _____

_____

Hobbies/Pastimes:

1) Do you have any hobbies? ☐Yes ☐No If yes, please describe: _____

_____

2) What are your favorite past-times?_____

_____

3) What activities do you least enjoy? _____

_____

			Performance			
What is your ability to: (Some questions apply only to one sex):	**Unable**	**Not Attempted**	**Fair**	**Average**	**Good**	**Comments**
1) Whistle?						
2) Blow a bubble with bubble gum?						
3) Drink through a straw?						
4) Blow a balloon?						
5) Use a razor for shaving?						
6) Use dental floss?						
7) Jump off the ground with both feet together?						
8) Pump on a swing?						
9) Kick a ball?						
10) Hop on one foot?						
11) Ride a bicycle?						
12) Jump rope?						
13) Skip?						
14) Rollerblade or ice skate fluidly?						
15) Snow ski?						
16) Do jig saw puzzles?						
17) Cut with scissors?						
18) Tie laces or a ribbon?						
19) Wrap a present?						

What is your ability to: (Some questions apply only to one sex):	Unable	Not Attempted	Fair	Average	Good	Comments
20) Manipulate snaps, buttons, and buckles?						
21) Cut with a knife?						
22) Snap fingers?						
23) Operate a can opener (manual/electric)?						
24) Put a belt through all belt loops?						
25) Tie a man's tie?						
26) Type or use a keyboard on a computer?						
27) Play games on a hand-held video "Game Boy" or a similar machine?						
28) Use a cordless or touch tone phone?						
29) Put in contact lenses?						
30) Put on aftershave all over face?						
31) Polish shoes with shoe polish?						
32) Open and close an umbrella?						
33) Use a copier machine?						
34) Reload paper in a fax machine or printer?						
35) Use a coffee maker?						
36) Swim using the crawl or other strokes (with coordinated breathing)?						
37) Float on back and stomach in the water?						

What is your ability to: (Some questions apply only to one sex):	Unable	Not Attempted	Fair	Average	Good	Comments
38) Change a tire?						
39) Back up while driving?						
40) Parallel park?						
41) Apply makeup?						
42) Style your hair?						
43) Put on pierced earrings and/or a necklace?						
44) Put on a watch?						
45) Blow-dry your hair?						
46) Blow your nose?						
47) Zip lining into a raincoat?						

1. What methods do you find most helpful to learn new tasks?

2. What are your strengths and gifts?

3. How have difficulties you are experiencing in any of the above areas affected your life?

4. Are there any particular skills you would like to be able to achieve?

5. Do you or anyone else in your family have similar difficulties? If so please describe below and/or mark pertinent sections of the questionnaire in a second color.

Signature _____ Date _____

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