



**School-Age Checklist
Occupational and Physical Therapy Services: 5-12 years**

Name: _____ **Age:** _____ **DOB:** _____ **Date:** _____

Please fill out the following checklist in order to help us determine the most appropriate evaluation for your child.

Does your child exhibit the following:	Yes, Frequently	Some- times	Never	Additional Comments
Gross Motor Skills				
1. Seems weaker or tires more easily than other children his/her age.				
2. Difficulty with hopping, jumping, skipping or running compared to others his/her age.				
3. Appears stiff and awkward in movements.				
4. Clumsy or seems not to know how to move body, bumps into things.				
5. Tendency to confuse right and left body sides.				
6. Hesitates to climb or play on playground equipment.				
7. Reluctant to participate in sports or physical activity; prefers table activities.				
8. Seems to have difficulty learning new motor tasks.				
9. Difficulty pumping self on swing; poor skills in rhythmic clapping games.				
Fine motor skills				
1. Poor desk posture (slumps, leans on arm, head too close to work, other hand does not assist).				
2. Difficulty drawing, colouring, copying, cutting, avoidance of these activities.				
3. Poor pencil grasp; drops pencil frequently.				
4. Pencil lines are tight, wobbly, too faint or too dark; breaks pencil more often than usual.				
5. Tight pencil grasp; fatigues quickly in writing or other pencil and paper tasks.				
6. Hand dominance not well established (after age six).				
7. Difficulty in dressing; clothing off or on, buttons, zippers, tying bows on shoes.				
Touch				
1. Seems overly sensitive to being touched; pulls away from light touch.				
2. Has trouble keeping hands to self, will poke or push other children.				
3. Touches things constantly "learns" through his/her fingers.				
4. Has trouble controlling his interactions in group games such as tag, dodge ball.				
5.. Avoids putting hands in messy substances (clay, finger paint, paste).				
6. Seems to be unaware of being touched or bumped.				
7. Has trouble remaining in busy or group situations, e.g., cafeteria, or circle time.				

(continued next page)

	Yes	Some	Never	Additional Comments
Movement and Balance				
1. Fearful moving through space (teeter-totter, swing).				
2. Avoids activities that challenge balance; poor balance in motor activities				
3. Seeks quantities of movement including swinging, spinning, bouncing and jumping.				
4. Difficulty or hesitancy learning to climb or descend stairs.				
5. Seems to fall frequently.				
6. Gets nauseated or vomits from other movement experiences, e.g., swings, playground merry-go-rounds.				
7. Appears to be in constant motion, unable to sit still for an activity.				
Visual perception				
1. Difficulty naming or matching colours, shapes or sizes.				
2. Difficulty in completing puzzles; trial and error placement of pieces.				
3. Reversals in words or letters after first grade.				
4. Difficulty coordinating eyes for following a moving object, keeping place in reading, copying from blackboard to desk.				
Auditory Language				
1. Appears overly sensitive to loud noises (e.g., bells, toilet flush).				
2. Is hard to understand when she/he speaks.				
3. Appears to have difficulty understanding or paying attention to what is said to him or her.				
4. Easily distracted by sounds; seems to hear sounds that go unnoticed by others.				
5. Has trouble following two-three step commands.				
Emotional				
1. Does not accept changes in routine easily.				
2. Becomes easily frustrated.				
3. Difficulty getting along with other children.				
4. Apt to be impulsive, heedless, accident-prone.				
5. Easier to handle in small group or individually.				
6. Marked mood variations, tendency to outbursts or tantrums.				
7. Tends to withdraw from groups; plays on the outskirts.				
8. Has trouble making needs known in appropriate manner.				
9. Avoids eye contact.				

Academic Difficulties

Reading Distractible Slow writer Following directions Phys. Ed.
 Math Restless Poorly organized Remembering information
 Spelling Hyperactive Finishing tasks Short attention span

How concerned are you about the above checked problems? **Not concerned** **Slightly** **Moderately** **Very**

Child's Name: _____ **Date of Birth:** _____ **Age:** _____ **Date completed** _____

Name of Case Manager/Therapist/Teacher: _____

Name of School: _____

Parent(s)' Name: _____

Signature of person completing form: _____ **Phone:** _____

Adapted from: OTA, 124 Watertown Street, Watertown, Maine, 021172 Tel: 717-923-4410; Fax: 617-923-0468

PLEASE ENTER YOUR QUESTIONS AND/OR COMMENTS BELOW

