

## Sensorimotor History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

Write a Y for Yes and N for No in the appropriate column.

<u>Y/N</u>	<u>QUESTIONS</u>	<u>COMMENTS</u>
	<p><b><u>TACTILE SENSATION:</u></b> Does the child:</p> <ol style="list-style-type: none"> <li>1. Object to being touched?</li> <li>2. Dislike being cuddled?</li> <li>3. Seem irritable when held?</li> <li>4. Prefer to touch rather than be touched?</li> <li>5. Dislike having hands dirty?</li> <li>6. Dislike having nails clipped?</li> <li>7. React negatively to the feel of new clothes?</li> <li>8. Bothered by clothing tags, fit of clothing?</li> <li>9. Prefer certain textures of clothing?</li> <li>10. Dislike having hair and/or face washed?</li> <li>11. Dislike having hair cut or combed?</li> <li>12. Prefer certain textures of food?</li> <li>13. Isolate/withdraw self from other children?</li> <li>14. Frequently bump and push or hit other children?</li> <li>15. Walk on a variety of surfaces; grass, sand, carpet, cement without distress?</li> </ol> <p><b><u>AUDITORY SENSATION:</u></b></p>	
	<p>Does the child:</p> <ol style="list-style-type: none"> <li>1. Seem overly sensitive to sound?</li> <li>2. Miss some sounds?</li> <li>3. Seem confused about the direction of sounds?</li> <li>4. Like to make loud noises?</li> <li>5. Have a diagnosed hearing loss?</li> <li>6. Frequent ear infections?</li> </ol> <p><b><u>OLFACTORY SENSATION:</u></b></p>	
	<p>Does the child:</p> <ol style="list-style-type: none"> <li>1. Explore the environment with smell?</li> <li>2. Discriminate odors?</li> <li>3. React defensively to smell?</li> <li>4. Ignore noxious odors?</li> </ol> <p><b><u>VISUAL SENSATION:</u></b></p>	
	<p>Does the child:</p> <ol style="list-style-type: none"> <li>1. Have a diagnosed visual defect?</li> <li>2. Have difficulty eye-tracking?</li> <li>3. Make reversals when copying?</li> <li>4. Have difficulty discriminating colors, shapes?</li> <li>5. Appear sensitive to light?</li> <li>6. Resist having vision occluded?</li> <li>7. Become excited when confronted with variety or visual stimuli?</li> </ol>	

**Sensorimotor History (continued)**

<b><u>Y/N</u></b>	<b><u>QUESTIONS</u></b>	<b><u>COMMENTS</u></b>
	<p><b><u>GUSTATORY SENSATION:</u></b> Does the child:</p> <ol style="list-style-type: none"> <li>1. Act as though all food tastes the same?</li> <li>2. Explore by tasting?</li> <li>3. Dislike foods of a certain texture?</li> </ol> <p><b><u>VESTIBULAR SENSATION:</u></b></p>	
	<p>Does the child:</p> <ol style="list-style-type: none"> <li>1. Dislike being tossed in the air?</li> <li>2. Seem fearful in space (i.e. going up and down stairs, riding Teeter-totter)?</li> <li>3. Appear clumsy, often bumping into things and or falling down?</li> <li>4. Prefer fast-moving, spinning carnival rides?</li> <li>5. Avoid balance activities?</li> </ol> <p><b><u>MUSCLE TONE:</u></b></p>	
	<p>Does the child:</p> <ol style="list-style-type: none"> <li>1. Have any diagnosed muscle pathology (i.e., spasticity, Flaccidity, rigidity, etc.)?</li> <li>2. Seem weaker or stronger than normal?</li> <li>3. Frequently grasp objects too tightly?</li> <li>4. Have a weak grasp?</li> <li>5. Tire easily?</li> </ol> <p><b><u>COORDINATION:</u></b></p>	
	<p>Does the child:</p> <ol style="list-style-type: none"> <li>1. Manipulate small objects easily?</li> <li>2. Seem accident prone (i.e. have frequent scrapes or bruises)?</li> <li>3. Eat in a sloppy manner?</li> <li>4. Have difficulty with pencil activities?</li> <li>5. Have difficulty dressing and/or fastening clothes?</li> <li>6. Have consistent hand dominance?</li> <li>7. Neglect one side of the body, or seem unaware of it?</li> </ol> <p><b><u>REFLEX INTEGRATION AND DEVELOPMENT:</u></b></p>	
	<ol style="list-style-type: none"> <li>1. Was the child slow to reach the usual developmental Milestones (i.e., sitting, walking, talking)?</li> <li>2. Was the child irritable in infancy, particularly when held?</li> <li>3. Does the child have difficulty isolating head movements?</li> <li>4. Does the child lack adequate protective reactions when falling?</li> </ol>	

**Developmental History:**

<b><u>AGE</u></b>	<b><u>PLEASE SPECIFY AGE AS NEAR AS POSSIBLE:</u></b>	<b><u>COMMENTS:</u></b>
	<p align="center">1. At what age did your child:</p> <ul style="list-style-type: none"> <li>a. Roll over both ways?</li> <li>b. Sit alone?</li> <li>c. Walk?</li> <li>d. Speak his first word (what was it)?</li> <li>e. Speak his first sentence (what was it)?</li> <li>f. Drink independently from a cup (what type)?</li> <li>g. Use a spoon independently (what type)?</li> <li>h. Feed himself independently</li> <li>i. Put on a shirt independently?</li> <li>j. Button independently?</li> <li>k. Dress himself independently?</li> </ul>	
<b><u>Y/N (Y=Yes/N=No)</u></b>	<b><u>PLEASE COMMENT AS NECESSARY:</u></b>	<b><u>COMMENTS:</u></b>
	<p align="center">2. Describe your child as an infant:</p> <ul style="list-style-type: none"> <li>a. Cried a lot, fussy, irritable</li> <li>b. Was good, non-demanding</li> <li>c. Was alert</li> <li>d. Was quiet</li> <li>e. Was passive</li> <li>f. Was active</li> <li>g. Liked being held</li> <li>h. Resisted being held</li> <li>i. Was floppy when held</li> <li>j. Was tense when held</li> <li>k. Had good sleep patterns</li> <li>l. Had irregular sleep patterns</li> </ul>	
	<p align="center">3. Describe your child at present:</p> <ul style="list-style-type: none"> <li>a. Is mostly quiet</li> <li>b. Is overly active</li> <li>c. Tires easily</li> <li>d. Talks constantly</li> <li>e. Too impulsive</li> <li>f. Is restless</li> <li>g. Is stubborn</li> <li>h. Is resistant to changes</li> <li>i. Overreacts</li> <li>j. Fights frequently</li> <li>k. Is usually happy</li> <li>l. Exhibits frequent temper tantrums</li> <li>m. Is clumsy</li> <li>n. Has difficulty separating from primary caretaker</li> <li>o. Has nervous habits or tics</li> <li>p. Falls often. Wets bed</li> <li>q. Has poor attention span</li> <li>r. Is frustrated easily</li> <li>s. Has unusual fears</li> <li>t. Rocks self frequently</li> <li>u. Has difficulty learning new tasks</li> </ul>	

**Developmental History (continued):**

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**4. Please describe your child's strengths:**

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**5. Please describe your concerns about your child's present skills and abilities:**

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**6. Additional Comments:**