Pediatric Therapy

Name: _____ Date: _____

Diagnosis: _____

Parent Name: _____ Phone: _____

❑ EVALUATE & TREAT ❑ OT ❑SPEECH

__ FUNCTIONAL ACTIVITIES
__ FINE MOTOR COORDINATION
__ GROSS MOTOR COORDINATION
__ VISUAL MOTOR/PERCEPTUAL SKILLS
__ POSTURAL TRAINING
__ BALANCE
__ STRENGTHENING
__ ROM (PROM, AAROM, AROM)
__ MYOFASCIAL RELEASE
__ ULTRASOUND (Older Children)
__ HEAT / COLD
__ SENSORY INTEGRATION
__ COGNITIVE RETRAINING
__ NEUROMOTOR RE-EDUCATION
__ ORAL MOTOR / FEEDING
__ HOME EXERCISE PROGRAM
__ WHEELCHAIR ASSESSMENT
__ ADAPTIVE EQUIPMENT
__ ADLS (Activities of Daily Living)
__ SPLINTING
__ BRACING
__ JOINT MOBILIZATION
__ ELECTRIC STIMULATION
__ PRIMITIVE REFLEXES
__ OTHER _____

SPEECH THERAPY

__ ARTICULATION/PHONOLOGICAL DISORDER
__ LANGUAGE PROBLEMS
__ ORAL MOTOR/SWALLOWING
__ OTHER _____
__ STUTTERING
__ HOME EXERCISE PROGRAM

COMMENTS: _____

_____

_____

FREQUENCY: 1 2 3 4 5 /Week DURATION: _____WEEKS

_____ M.D.

_____ M.D. Printed Name

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