Pediatric Therapy

Name: ___________________________________ Date:

Diagnosis: ____

Parent Name: _____________________________ Phone: _____________

❑ EVALUATE & TREAT ❑ OT ❑SPEECH

__ FUNCTIONAL ACTIVITIES
__ COORDINATION
__ VISUAL MOTOR/PERCEPTUAL SKILLS
__ POSTURAL TRAINING
__ BALANCE
__ STRENGTHENING
__ ROM (PROM, AAROM, AROM)
__ PARENTAL TRAINING
__ SOCIAL SKILLS TRAINING
__ MENTAL HEALTH
__ SENSORY INTEGRATION

__ COGNITIVE RETRAINING
__ NEUROMOTOR RE-EDUCATION
__ ORAL MOTOR / FEEDING
__ HOME EXERCISE PROGRAM
__ WHEELCHAIR ASSESSMENT
__ ADAPTIVE EQUIPMENT
__ ADLS (Activities of Daily Living)
__ SPLINTING
__ BEAHAVIORAL
__ JOINT MOBILIZATION
__ ELECTRIC STIMULATION
__ PRIMITIVE REFLEXES

__ OTHER ____

SPEECH THERAPY

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

COMMENTS: ____

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

____ M.D.

____ M.D. Printed Name

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