



978.254.7726
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Client's Name: _____

Client's Birthdate: _____

Parents Names (If Client is a Minor):

Form Completed by: _____

Date Form Completed: _____

Preferred E-Mail: _____

Preferred Telephone Contact: _____

Primary Mailing Address:

Secondary Mailing Address:

	PREGNANCY AND DELIVERY ISSUES	TRUE	FALSE	NOT SURE	COMMENTS
1	Mother had bleeding during pregnancy				
2	Mother had hyper-emesis during pregnancy				
3	Mother had Toxemia				
4	Mother on bed rest during pregnancy				
5	Mother had an infection during pregnancy				
6	Mother had an injury during pregnancy				
7	Client was a multiple				
8	Was born via cesarean section				
9	Needed forceps during delivery				
10	Client was born early				
11	Client was born late				
12	Client's birth/delivery was difficult				
13	Client was born with heart defect				
14	Client had trouble sucking				

	CLIENT HEALTH ISSUES	TRUE	FALSE	NOT SURE	COMMENTS
1	Seizures				
2	Intensive Care Hospitalizations				
3	Asthma				
4	Allergies				
5	Frequent Ear infections &/or tubes put in				
6	Frequent use of antibiotics- past or present				
7	Constipation- past or present				
8	Gastrointestinal issues				
9	Head injuries				
10	Lead poisoning				

	FAMILY ROUTINES	T	F	NS	COMMENTS
1	Family dinners (at the table) are common occurrences				
2	Bedtime routines/ bedtimes are firmly established				
3	Whole family is present for dinner & evening hours				
4	Healthy meals & snacks are valued				
5	Child chores are part of the weekly routine				
6	My child receives an allowance				
7	Client has a consistent place to take a "time out"				
8	Client has plenty of unstructured "down time"				

	DEVELOPMENTAL ISSUES	TRUE	FALSE	NOT SURE	COMMENTS
1	Client was difficult to sooth as baby				
2	Client had feeding issues- lots of dribbling/ difficulty with textures/ solid foods				
3	Client needed help to sit up after 6 months				
4	Client wasn't crawling by 9 months				
5	Client crawled in a creative way				
6	Client never really crawled				
7	Client walked early (before a year)				
8	Client frequently walks/ walked on toes				
9	Client felt rigid/ tense when being held as a child				
10	Client waked down stairs without alternating feet after 4 years old				
11	Client was a late talker				
12	Client was an early talker				

	DEVELOPMENTAL ISSUES CONTINUED	TRUE	FALSE	NOT SURE	COMMENTS
13	Client had difficulty using a spoon/ fork after 3 years old				
14	Client had awkward grasp of spoon/fork after 5 years old				
15	Client had difficulty using a knife after 8 years old				
16	Client retained bedwetting after 5 years old				
17	Trouble with buttoning/zipping or tying shoes effectively after age 6				
18	Client had difficulty learning basic gross motor tasks				
19	Client is clumsy or tends to bump into things				
20	Client has/had difficulty catching a ball				
21	Client has/had difficulty throwing a ball				
22	Client has difficulty expressing their needs				
23	Client has articulation issues/ unclear speech/stuttering				
24	Client has difficulty using scissors, tape, pencils				
25	Difficulty drawing basic shapes, including a triangle after age 5				
26	Client wears only certain types of clothes				
27	Client avoids being hugged or touched by others				
28	Client seems overly aware of things in the environment (vigilant)				
29	Client seems unaware of things in the environment				
30	Client has awkward postures or extraneous mouth/tongue movements when performing motor tasks				

	CHIDHOOD BEHAVIORAL CONCERNS	TRUE	FALSE	NOT SURE	COMMENTS
1	Overly shy				
2	Difficulty with change in routine				
3	Too much energy				
4	Not enough energy				
5	Tendency to over react to noise or touch				
6	Tendency to get over excited in group activities				
7	Fidgety- can't sit still				
8	Sits on feet or wraps feet around chair legs				
9	Has difficulty remaining seated during meal time				
10	Struggles to settle down for homework				
11	Homework takes a LONG time				
12	Resists new ways of doing things/sticks with old, ineffective patterns				
13	Difficulty with eye contact				
14	Temper Tantrums				
15	Cries often and easily				

	CHIDHOOD BEHAVIORAL CONCERNS CONTINUED	TRUE	FALSE	NOT SURE	COMMENTS
16	Difficulty focusing at home/ easily distracted by environment				
17	Difficulty focusing at school/ easily distracted by environment				
18	Difficulty with impulse control, delaying gratification, waiting				
19	Reluctant to engage in tasks requiring sustained mental effort				
20	Difficulty falling asleep by him/her self- long bedtime routine				
21	Picky eater- limited food choices or amounts				
22	Won't drink water				
23	Messy eating habits- takes large bites- face close to plate				
24	Personal space issues				
25	Talks excessively				
26	Climbed a lot as a toddler				
27	Difficulty modulating speed of doing things: works too fast or too slow				
28	Often crashes or "falls" to the ground when running, playing or during sports				
29	Difficulty maintaining rhythm				
30	Expresses feelings of failure and low self esteem				
31	Has social difficulties at school				
32	Interrupts adults				
33	Reluctant to play on playground structures or to participate in sports				
34	Fearful of activities moving through space (bicycle, cars, amusement parks, swings)				
35	Has unusual fears of the dark, going upstairs alone, escalators				
36	Often knocks things over or spills items				
37	Often turns paper or shifts body when drawing/writing/ coloring				
38	Misplaces/loses things regularly				
39	Difficulty keeping track of daily schedules, reduced awareness				
40	Difficulty coming up with solutions to problems				
41	Often answers simple questions with "I don't know"				
42	Needs many reminders to put away toys, hang up jacket, etc..				

	LEARNING STYLES	TRUE	FALSE	NOT SURE	COMMENTS
1	Freeze in new learning situations/ blank stare				
2	Resists or fights about doing new things				
3	Tries hard with lots of effort				
4	Acts without thinking				
5	Says "I can't" before trying activities				
6	Prefers and seems to need hands on activities to stay focused				
7	Reads "all the time"				
8	Resists going outside				
9	Likes thing IN ORDER - upset when not				
10	Has difficulty following verbal expression				
11	Often tries to negotiate around doing things				
12	Doesn't seem to hear their name being called				
13	Difficulty understanding the passage of time, estimating time				
14	Trouble telling time				
15	Doesn't use time wisely				
16	Difficulty remembering sequences- numbers, alphabet, days of the week, months of the year				
17	Difficulty with letter sounds- sounding out words				
18	Seems to need extra time to process verbal information- delayed responses				
19	Doesn't do as well in "circle time" or class discussions- loss focus				
20	Complains of headaches or watery eyes or strain				
21	Skips words or repeats lines when reading				
22	Tilts head or closes one eye when reading or writing				
23	Difficulty copying from board				
24	Difficulty taking notes during class				
25	Often mixes up sequences of letters when writing				
26	Shows difficulty in reading comprehension				
27	Shows difficulty in math				
28	Shows difficulty in writing				
29	Shows difficulty in spelling				
30	Breaks pencil tips often or uses heavy pressure during writing				
31	Has messy handwriting/ works slowly to produce quality output				
32	Has difficulty with manipulating materials- i.e. paper into folder, using paperclips, zipping backpack, zip lock bags				
33	Difficulty organizing materials				
34	Difficulty with left and right on self or in environment				
35	Reversals in writing after 1st grade				

	LEARNING STYLES	TRUE	FALSE	NOT SURE	COMMENTS
36	Doesn't seem to recognize errors				
37	Doesn't seem to learn from mistakes - trial and error approach				
38	Takes comments very literally- doesn't get jokes				
39	Difficulty understanding sarcasm or tones of voices				
40	Difficulty listening in noisy environments				
41	Has trouble planning out work				
42	Does not use strategies				

Please share about your child or your self (whomever happens to be the client):

What are their/ your strengths?

What are their/ your interests?

What type of positive reinforcement does your child/ do you prefer?

What are your concerns that brought you to completing this form?

Is the client fully or partially vaccinated? If so, please share the list of vaccinations received and the age at which the vaccines were given.

Does your family follow any special or exclusionary diets?

Have you noticed any digression of physical/ emotional development? If so, please share what you've noticed.

Which of the following 3 areas or skills are causing the MOST concern at the time?

- Self-esteem
- Organization
- Fears/ anxiety
- Ability to "stop & think"
- Attending to details
- Self reflection/ self awareness
- Persistence/ sustained attention
- Awareness of environment
- Transitioning
- Problem solving
- Settling down/ concentrating to complete tasks
- Sleep issues- falling/ staying asleep
- Body control/ balance
- Sitting still
- Gross motor skills/ coordination
- Fine motor skills/ eye-hand coordination
- Tolerating feedback/ making mistakes
- Beginning academic skills (4-6 year olds)
- Inability to multitask- works very slowly
- Listening and following directions
- Making decisions
- Responding appropriately to questions

The key to primitive reflex integration is intentional movement & activity patterns that allow the body/mind to realign. You can reverse developmental delays, as well as support innate growth & maturity by partnering with Primitive Reflex Integration Developmental Specialists.

* Checklist adopted and adapted with permission of Brain Fit Academy, Inc., Hopedale, Ma.