 Paula Lynam

 Developmental, Family & Educational Support

Assisting in the healthy development of children, thei families and schools through movement, sensory integration, play, and therapeutic arts.

**PLEASE FILL THIS OUT AND RETURN TO ME, INCLUDING PAYMENT, PRIOR TO THE ASSESSMENT – Thank you.**

**ASSESSMENT INTAKE FORM**

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| **NAME: DATE:** |
| **BIRTHDATE/AGE: SCHOOL:** |
| **NAME OF PERSON COMPLETING FORM:** |
| **PHONE:**  **E-MAIL:**  **ADDRESS:** |
| **APT. DATE/TIME:** |
| **FOLLOW-UP APT. DATE/TIME:** |

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| **CLOTHING** |
| 1. Appears bothered by clothing in general |
| 1. Is bothered by tags in shirts**.** |
| 1. Is bothered by seams in socks. |
| 1. Is bothered by stiff fabrics. |
| 1. Wears long sleeves and does not remove jacket. |
| 1. Refuses to wear synthetics. |
| 7. Other: |
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| **HUMAN TOUCH/CONTACT** |
| 1. Is bothered by light touch. |
| 2. Seeks deep touch/compression. |
| 3. Is ticklish. |
| 4. Hits, pushes, kicks others. |
| 5. Has difficulty stopping rough housing. |
| 6. Needs to sit on, snuggle up to other. |
| 7. Complains about pain (falls, cuts, etc.) |
| 8. Sustains eye contact. |
| 9. Is aware of nonverbal communication. |
| 10. Other: |
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| **GROOMING** |
| 1. Appears uncomfortable in water. |
| 1. Gets upset when needs to leave water. |
| 1. Gets hysterical when washing hair. |
| 1. Is extremely bothered by wet clothes. |
| 1. Seems uncomfortable when dirty, sandy, etc. |
| 1. Appears not to notice food on face. |
| 1. Complains about face washing. |
| 1. Complains about hair combing/brushing, haircuts. |
| 1. Complains about nail cutting. |
| 1. Complains about tooth-brushing. |
| 11, Other. |
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| **FOODS** |
| 1. Is a fussy eater in general. |
| 1. Dislikes chewy foods. |
| 1. Dislikes foods or juices due to texture. |
| 1. Dislikes mixtures of textures in foods. |
| 1. Dislikes most vegetables. |
| 1. Eats sweets – how often? |
| 1. Craves salt. |
| 1. Eats a lot of mayo., margarine, fried foods. |
| 1. Drinks cola, coffee, regular tea – how often? |
| 1. Eats chocolate. |
| 1. How much dairy? |
| 1. Drinks at least 4 cup water daily. |
| 1. List supplements taking currently. |
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| 1. Has food allergies. |
| 1. Eats meat, fish, eggs, poultry. |
| 1. Other: |
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| **SOUNDS** |
| 1. Is bothered by sound in general. |
| 1. Hums or makes white noise when concentrating. |
| 1. Is bothered by high pitched, unexpected or loud sounds. |
| 1. Tunes out conversation or directions. |
| 1. Speaks in loud voice. |
| 1. Other: |
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| **ODORS** |
| 1. Is bothered by strong odors. |
| 1. Generally brings food to nose to smell before tasting. |
| 1. Smells most objects. |
| 1. Smells people’s hair and clothes. |
| 1. Is bothered by food cooking or cafeteria smells. |
| 1. Appears insensitive to odor in general. |
| 1. Has stuffed nose; is a mouth breather. |
| 1. Other: |
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| **MOTION** |
| 1. Suffers from motion sickness in general. |
| 1. Falls asleep in moving vehicle. |
| 1. Enjoys merry-go-rounds/swings. |
| 1. Wants to continue swinging, spinning. |
| 1. Engages in a lot of bumping. |
| 1. Avoids most movement. |
| 1. Runs rather than walks. |
| 1. Bumps into things/people in path. |
| 1. Tips/tilts head much of the time. |
| 10. Exhibits balance problems. |
| 11. Engages in head banging, hand flapping etc. |
| 12. Frequently walks on toes. |
| 13. Other. |
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| **SLEEP** |
| 1. Requires being rocked to sleep. |
| 1. Upon awakening has difficulty walking, eating. |
| 1. Has trouble falling asleep in general. |
| 1. Has trouble sleeping with background noise. |
| 1. Has trouble sleeping with lights on. |
| 1. Needs music/tapes to fall asleep. |
| 1. Has trouble falling asleep in the dark. |
| 1. Awakens frequently in the night. Reason. |
| 1. Falls out of bed. |
| 10. Moves in bed quite a lot when sleeping. |
| 11. Sleepwalks. |
| 12. Needs other person in bed in order to sleep. |
| 13. Dislikes top sheet on bed. |
| 14. Grinds teeth in sleep. |
| 15. Other. |
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| **HEALTH FACTORS** |
| 1. Has numerous allergies that affect breathing. |
| 1. Has numerous allergies causing rashes etc. |
| 1. Suffers from headaches. |
| 1. Has visible discoloration under eyes. |
| 1. Frequently blinks or squints eyes. |
| 1. Frequently rubs eyes or has red eyes. |
| 1. Suffers from ear infections. |
| 1. Suffers from high fevers. |
| 1. Suffers from sinus problems. |
| 1. Has dentition/orthodontic problems. |
| 1. Has digestive disorders. |
| 1. Has difficulty with bowel or bladder control. |
| 1. Has serious or chronic illnesses. |
| 1. Has serious or repeated injuries/accidents. |
| 1. Takes medication. |
| 1. Has unusual reaction to immunizations. |
| 1. Has metabolic problems. |
| 1. Had difficult prenatal experience. |
| 1. Describe birth. |
| 1. Lost first tooth? Age? |
| 1. Other: |
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| **DEVELOPMENTAL MILESTONES** |
| 1. Breast or bottle fed. |
| 1. Age when rolled over. |
| 1. Age when sat up and pulled self up. |
| 1. Describe crawling. |
| 1. Describe walking. |
| 1. Describe talking. |
| 1. Describe dressing self. |
| 1. Difficulty/delay going up or down stairs. |
| 1. Difficulty/delay feeding self. |
| 1. Difficulty/delay drawing or writing. |
| 1. Difficulty/delay reading. |
| 1. Difficulty/delay deciding hand dominance. |
| 1. Difficulty/delay playing ball sports. |
| 1. Difficulty/delay with rhythm activities. |
| 1. Other. |
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| **HOBBIES, SPECIAL INTERESTS, TALENTS** |
| 1. Listening to music. |
| 1. Participating in music. |
| 1. Reading or listening to stories. |
| 1. Watching television or videos. How much? |
| 1. Computer games How often? |
| 1. Participating in sports (list). |
| 1. Observing sports activities. |
| 1. Hiking. |
| 1. Imaginative play. |
| 10. Bike riding. |
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| **LIGHTS** |
| 1. Is bothered by light in general. |
| 1. Appears bothered by lights in supermarkets. |
| 1. Appears uncomfortable with fluorescent lights. |
| 1. Wants to wear a cap with visor. |
| 1. Prefers bright lights to dim lights. |
| 1. Other: |
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| **ATTENTION** |
| 1. Has difficulty paying attention in school. |
| 1. Has difficulty completing tasks. |
| 1. Has difficulty accepting change/transitions. |
| 1. Has difficulty sitting still at home or school. |
| 1. Has difficulty following directions. |
| 1. Has difficulty organizing personal belongings. |
| 1. Other: |
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| **SPECIFIC EDUCATIONAL CONCERNS:** |
| **SPECIFIC SOCIAL CONCERNS:** |
| **ADDITIONAL COMMENTS:** |





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