Angel Care Kids Therapy Center
70 Merrimack Street
Haverhill, MA 01830

EARLY CHILDHOOD (BIRTH TO 3 YEARS)

AUDITORY

1. Does your child seem to be overly sensitive to sounds or overreact to noises in the environment?
2. Does your child become easily overwhelmed and not able to self-calm when there is noise, e.g. radio, vacuum, appliances, parties?
3. Does your child seem to not respond to noises or loud sounds as you would expect them to?
4. Does your child have difficulty following simple commands?

TACTILE

1. Does your child dislike being held, avoid cuddling and swaddling?
2. Does your child dislike car seats and seat belts?
3. Does your child cry excessively during diaper changes or dressing activities.
4. Does your child have difficulty with the changing of seasonal clothing?
5. Does your child over-react to nail care, hair care, and oral hygiene?
6. Does the texture of certain fabrics, sheets, blankets significantly bother your child?
7. Does your child avoid activities or play due to tactile sensitivities, e.g. rice, sand, playdough?
8. Does your child have difficulty tolerating socks and shoes?
9. Does your child avoid splashing water or water on their head and face?
10. Does your child engage with you and other family members?
11. Do you feel that sensitivities to tactile input are disrupting your child's activities of daily living skills?

ORAL MOTOR

1. Is your child able to nurse or drink effectively from a bottle or sippy cup?
2. Did your child have difficulty transitioning from liquids to solid food?
3. Does your child have difficulty tolerating various foods textures and tastes?
4. Does your child gag or over-stuff their mouth?
5. Does your child excessively drool or have difficulty keeping their mouth closed.
6. Is your child a thumb-sucker or user of a pacifier?
7. Does your child have delayed speech?

8. Does your child excessively mouth or chew on non-food items?
9. Is your child over or under sensitive to taste and smells?

VISUAL

1. Does your child make good eye contact and able to focus on visual stimuli presented to them?
2. Does your child seem bothered in very stimulating environments or have sensitivity to bright lights or sunlight?
3. Is your child able to visually track items and localize items in their environment?
4. Does your child have difficulty with puzzle and constructional activities?

MOVEMENT

1. Does your child avoid baby swings, playground equipment, amusement park rides or other movement activities?
2. Does your child dislike car rides or become car sick or motion sick?
3. Does your child frequently seek movement or input, e.g. rocking, banging, crashing, jumping, twirling, always moving and fidgeting?
4. Does your child have excessive fear of movement or of trying new activities?
5. Does your child appear fearful of heights or being upside down?
6. Does your child demonstrate excessive risk taking during movement activities?
7. Has a dislike or fear of movement limited your child's participation in gym activities?
8. Does your child exhibit a hand preference for motor tasks?
9. Was your child delayed in gross or fine motor skill development?

SOCIAL/FUNCTIONAL

1. Do you feel like your child is social?
2. Does your child interact with other children and adults?
3. Does their play seem appropriate for their age?
4. Do they have restricted interests or limited playing skills?
5. Was your baby described as being colicky and then did not respond to traditional treatment?
6. Would you ever describe your child as being difficult to control, difficult to calm, difficult to satisfy?
7. Does your child have significant tantrums?
8. Does your child have difficulty with transitions, change in routine, and change in schedules?

If you answered "yes" to 5 questions in this checklist, it is recommended that you speak with a pediatric occupational therapist and share this checklist with your child’s physician.