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

ADOLESCENT

AUDITORY

1. Does your child seem to be overly sensitive to sounds or overreact to noises in the environment, e.g. home, classroom?
2. Does your child seem overwhelmed and not able to focus when there is noise, e.g. car radio, vacuum, appliances, parties?
3. Does your child not seem to respond to loud sounds or react as you would expect?
4. Does your child have difficulty following simple commands and directions for completion of schoolwork and homework?
5. Is your child easily distracted and have difficulty focusing and staying on task?
6. Does your child have difficulty sustaining attention to the classroom teacher or a speaker?
7. Does your child over react to school sounds such as bells, fire alarms, sounds in the gym or cafeteria?
8. Does your child have difficulty traveling on the school bus?
9. Is your child unable to filter out unnecessary sounds or background noises?

TACTILE

1. Does your child exhibit difficulty with touch, dislike being hugged, have difficulty standing in line, being in close proximity to others?
2. Does your child have difficulty in gym class?
3. Does your child dislike or avoid seat belts and car/booster seats?
4. Does your child overreact to hair care, nail care and oral care?
5. Does your child have difficulty at dental appointments?
6. Does the texture of certain fabrics, sheets, blankets, significantly bother your child?
7. Does your child have difficulty tolerating seasonal changes in clothes such as hats, jackets, shorts, accessories, etc.?
8. Does your child appear to avoid working with certain materials (glue, paint) due to a tactile issue?
9. Does your child express discomfort when wearing socks and shoes?
10. Does your child avoid getting messy or overreact when dirty or wet?
11. Does your child have difficulty with personal hygiene?
12. Do you feel that sensitivities to tactile input are disrupting or limiting your child's activities of daily living?

ORAL MOTOR

1. Does your child have difficulty tolerating various food textures and tastes?
2. Does your child gag or overstuff their mouth?
3. Does your child have a speech delay?
4. Does your child excessively mouth or lick objects and non-food items?
5. Does your child chew on non-food items, pen caps, etc.?

VISUAL

1. Does your child have difficulty with eye contact and unable 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. Does your child have difficulty visually tracking items and inaccurate at localizing items in their environment?
4. Does your child have difficulty with puzzle and constructional activities?
5. Does your child have difficulty assembling items?
6. Does your child seem to have difficulty managing their visual space and/or classroom materials?
7. Does your child appear to have figure-ground problems?
8. Has your child developed a solid hand preference and functional pencil grasp?
9. Does your child have difficulty copying designs and reproducing designs and written work?
10. Is your child successful with script and cursive handwriting?
11. Does your child have difficulty with computer keyboarding skills?
12. Does your child have difficulty copying from the blackboard?
13. Does your child appear to become over stimulated when there is a lot of information on a page or paper?
14. Does your child lose their place when reading or writing?

MOVEMENT

1. Does your child avoid 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 of 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 or bike riding, sports, etc.?
8. Is your child able to ride a bike or scooter?
9. Would you describe your child as awkward or clumsy?
10. Does your child fall or trip easily?
11. Is your child able to sustain an upright posture throughout an activity, dinner, movie, homework, etc.?
12. Does your child have difficulty negotiating themselves through their environment?
13. Does your child have delays in gross or fine motor skills?

SOCIAL/FUNCTIONAL

1. Do you feel like your child is social?
2. Does your child interact with other children and adults?
3. Does your child's play seem appropriate for their age?
4. Do they have restricted interests or limited play skills?
5. Do they experience difficulty in large groups?
6. Do they have difficulty making friends?
7. Can your child read social cues, facial expressions and body language?
8. Does your child exhibit good coping skills and problem solving?
9. Would you ever describe your child as being difficult to control, difficult to calm, difficult to satisfy?
10. Does your child have significant tantrums?
11. Does your child have difficulty with transitions, change in routine, and change in schedules?
12. Is your child rigid and follow rituals and routines?
13. Does your child exhibit excessive fears, anxiety, or rage?
14. Do you feel that your child is vulnerable and that you have to protect your child more than other children?

ORGANIZATION

1. Does your child have difficulty organizing themselves and their personal belongings?
2. Does your child have difficulty organizing their homework, folders, locker, backpack, etc.?
3. Does your child have difficulty initiating activities and following directions?
4. Does your child know how to initiate and sequence a book report or project?

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.