BOONE CLINTON JOINT SERVICES

PHYSICAL THERAPY SCREENING QUESTIONNAIRE

Child's Name_____ **Date**_____
School_____ **DOB**_____
Teacher/Grade_____ **Age**_____

Is child receiving special education services? _____Yes _____No

Please check all that are appropriate. Underline or circle the most significant problems. Please feel free to comment as needed.

Postural Skills
_____ Fatigues quickly, becomes short of breath easily, arms or legs seem limp
_____ Poor sitting posture, slumps in chair, head on hands when writing

Gross Motor/Motor Planning
_____ Has difficulty learning new motor skills, i.e. gym, playground, classroom projects
_____ Avoids or dislikes the playground, doesn't climb on the equipment
_____ Dislikes gym or sports, reluctant participant, prefers sedentary activities
_____ Difficulty following one-step directions
_____ Difficulty following multi-step directions
_____ Difficulty hopping, skipping, jumping, running, catching, throwing and/or kicking

Movement and Balance
_____ Fearful on playground equipment
_____ Avoids activities that require balance
_____ Seems to be always moving, seeks movement activities
_____ Has difficulty sitting still
_____ Fearful of heights or stairs
_____ Poor safety awareness
_____ Poor body awareness
_____ Appears clumsy or awkward
_____ Bumps into people or things and/or drops things (spatial awareness)

Functional Mobility
_____ Difficulty getting on and off the bus
_____ Unable to move through crowded hallway
_____ Difficulty navigating through school environment (stairs, through doorways, etc)
_____ Unable to transition smoothly (moving from sit to stand, to/from chair or floor)
_____ Struggles with reaching for objects on floor, shelves or desk
_____ Difficulty with use of locker, carrying lunch tray, finding way to/or around classroom

Comments: