PLEASE COMPLETE AND BRING TO YOUR EVALUATION APPOINTMENT:

What concerns you most about your child's mobility/self-care skills?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What exercises and/or activities are you currently doing with your child at home?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What would you like to see your child do in the next 6-12 months?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Think about a typical day with your child. Check boxes beside items your child needs to do, wants to do, or is expected to do; ***BUT*** currently is not doing, has difficulty doing, or you are not satisfied with how you and your child are doing the task.

- ☐ Self-feeding with fingers or utensils ___
- ☐ Using cup, straw, or bottle ___
- ☐ Eating & drinking (chewing food, keeping liquid in mouth) ___
- ☐ Dressing & undressing upper body ___
- ☐ Dressing & undressing lower body ___
- ☐ Moving on floor (rolling, playing, sitting, crawling, etc.) ___
- ☐ Moving around house ___
- ☐ Getting up off floor (to chair, standing, etc.)___
- ☐ Getting on & off toilet ___
- ☐ Using toilet ___
- ☐ Washing hands ___
- ☐ Getting in & out of tub/shower ___
- ☐ Bathing/showering ___
- ☐ Brushing teeth ___
- ☐ Getting in & out of house ___
- ☐ Getting in & out of vehicle ___
- ☐ Moving long distances (school, community, at grocery store, etc.) ___
- ☐ Moving on uneven surfaces (grass, dirt, stairs, ramps, thresholds, etc.) ___
- ☐ _____

Now think about each of the checked items above. How important is it to you or your child to be able to do this activity? Write a number next to each checked item in the list above.

1 2 3 4 5 6 7 8 9 10

not important at all extremely important

County of Sacramento

California Children's Services
Medical Therapy Program

Starr King Medical Therapy Unit

4848 Cottage Way
Carmichael, CA 95608

_____

is scheduled for a therapy evaluation.

Date: _____

Time: _____ **am pm**

☐ **OT** _____

☐ **PT** _____

Please call within 24 hours if you need to cancel or re-schedule your appointment
Starr King MTU Phone #: (916) 876-8877

WHAT WILL HAPPEN AT THE EVALUATION?

We will begin with a conversation to identify your child's needs and your family's concerns. We then complete an evaluation of your child's ability to participate in his or her daily routines and activities.

The physical and/or occupational therapist will address the following with you:

- Discussing concerns that you or other care givers may have about your child's mobility and self-care abilities
- Assessing for any specialized equipment or bracing that may benefit your child and/or check the fit of equipment and braces your child has now to find out if they are still working well or if adjustments are needed
- Setting functional goals
- Determining your child's readiness for therapy and the number of therapy sessions needed to reach the goals

Who should come to the appointment?

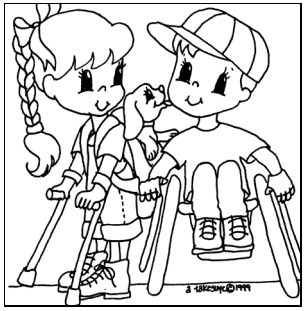
- Your child
- Parent/ legal guardian

*****Please arrange child care for young siblings if possible so that you may dedicate your full attention to this appointment.*****

PREPARING FOR THE EVALUATION:

Your child should wear:

- Shorts and t-shirt or loose-fitting clothing



What to bring:

- Equipment such as walkers, crutches, helmets, wheelchairs, splints, braces, etc.
- Glasses and hearing aides
- Names of doctors and other medical specialists
- List of medications
- Information about hospitalizations and surgeries
- Name of school, district, and status of IEP
- Food for oral motor evaluation that your child likes or will eat
- Favorite toy

Please check the statement that best describes your child.

_____ My child is interested in and able to take part in learning a new skill or activity.

_____ My child is interested in learning new skills and activities but has trouble participating.

_____ My child sometimes seems interested in practicing new skills or activities.

_____ My child gets fussy when we practice new skills or try activities.

_____ My child cries, has tantrums, or gets very upset and refuses to practice new skills or activities.

Please check the statement that best describes your availability to participate in therapy at this time

_____ My schedule is flexible and I can attend and take part in therapy sessions any day of the week, any time of day, and any number of days.

_____ My schedule is flexible and I can attend and actively participate in therapy sessions 1-3 times per week.

_____ My schedule is less flexible, but I can attend and take part in therapy sessions 1-2 times a month.

_____ My schedule will allow me to attend and take part in therapy sessions 4-6 times a year.

_____ My schedule will allow me to attend and take part in therapy sessions 2 times per year.

I prefer: (Circle one)
Day: M T W TH FRI
Time: _____ AM PM