

Observational Checklist

Instructions: In order to help us better understand the needs of your child, please review and place a check by those comments that apply. Check all that seem to describe your concerns.

Child's Name _____

Date _____

- Seems weaker than peers
- Seems to get tired easily as compared to peers
- Difficulty with hopping, skipping, running, etc. as compared to peers.
- Appears stiff and/or awkward when moving
- Clumsy- bumps into objects or people, falls or stumbles frequently
- Avoids playground equipment or may not try new equipment
- Poor posture- cannot sustain upright standing/sitting postures
- Difficulty initiating movements
- Difficulty using both sides of the body ie: right and left
- Awkward gait, unsteady walking, drags feet
- Difficulty imitating movements
- Resists organized group activities
- Seems to forget motor activities that he/she previously was able to do
- Holds body in strange positions for periods of time
- Did not crawl at all
- Crept on stomach rather than hands and knees
- Walks on toes, or did when younger
- Fearful of being off the ground
- Carsickness
- Likes a lot of movement- craves bouncing, swinging, rocking.
- Avoids balance activities
- Difficulty playing catch
- Cannot complete age appropriate puzzles
- Unable to negotiate obstacles while walking
- Frequently bumps into walls