

TEACHER/THERAPIST EVALUATION FORM

Child's name: _____ Date of Birth: _____

School: _____ Type of school: _____

Number of children in class: _____ Teachers/adults in class: _____

Special services/therapies for this child:

Please compare this child developmentally to other children his/her age
(including both strengths and areas which require support):

Physical Development:

A. General Appearance Normal ____ Atypical ____

B. Physical Handicaps (describe): _____

C. Sensory Handicaps (describe): _____

	Good	Fair	Poor
D. Gross motor skills	_____	_____	_____
E. Fine motor skills	_____	_____	_____
F. Drawing skills	_____	_____	_____

G. Comments: _____

Speech and Language

1. Does this child speak English? _____
2. Is this child bilingual? _____ What language? _____
3. Does this child understand and use gesture language? _____
4. Does this child use complete sentences? _____
5. Does this child use age-appropriate vocabulary? _____
6. Does this child maintain conversational exchanges? _____
7. Does the child appear to understand what is said to him? _____
8. Does the child follow directions only with gestures? _____
9. Does the child follow directions even without gestures? _____

Comments: _____

Behavior and Affect

Please describe strengths and as well as unusual or atypical behavior:

Social skills (ability to initiate and maintain interactions)

Relationship to adults

Relationship to peers

Play (ability to play with others, imaginative play, need for adult supervision, etc)

Self Help (if appropriate for age)

	Completely Dependent	Needs some help	Completely Independent
Toileting	_____	_____	_____
Feeding	_____	_____	_____
Dressing	_____	_____	_____
Washing	_____	_____	_____

