



# Smiley Steps

Conductive Education Centre

## Assessment Form

Cerebral Palsy Care  
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Charity number 1041434

## Personal Details

Child's name:
Date of birth:
Number of children in the family/age/sex:
Home address:
Home telephone number:
Mother's name:
Place of work:
Contact number:
Mobile number:
Father's name:
Place of work:
Contact number:
Mobile number:
Emergency contact number:
Name of siblings, pets and other information we can use to make your child feel at home.

Diagnosis given:
First indication of problems:
Additional comments:

## History of pregnancy

Length of pregnancy:
Premature/Normal/Post mature
Details of birth/ after birth:
Has your child had any breathing problems during or after birth?
Apgar score:

## Medical Information

Name/Address of GP and Paediatrician:

Medication:

Illnesses/Epilepsy

Allergies:

Has your child had any of the following tests? (MRI, CAT, EEG, ECG, X-ray, Video Fluoroscopy etc.)

Operations:

## Motor development

Please describe your child present abilities.

Muscle tone:
Rolling:
Creeping, crawling:
Sitting up/ Sitting:
Standing up/ Standing:
Walking:
Comments:

## Vision

Date of last test:
Outcome:
Does your child follow things with their eyes i.e. a person walking across a room, a moving toy etc?
Comment:

## Hearing

Date of last test:
Outcome:
Does your child respond to his/her name?
Does your child look towards the sound of things?
Comment:

## Eating & Drinking

Is your child able to finger feed?
Tube feeding:
Chewing
Swallowing:
Any additional problems with eating? Does your child have any difficulty with certain foods?
Does your child have any difficulties with drinking? What does your child use to drink from?
Dribbling:
Special diet:
Comments:

## Communication

Is your child able to speak?

Does your child make any sounds either in response to your voice or for their pleasure?

How does your child make their likes, dislikes and needs known to you?

- a. Facial expression
- b. By gestures
- c. By sounds

Has he/she a way of indicating YES or NO?

Does your child join in songs or nursery rhymes?

Do you use any forms of sign language or augmentative communication system?

## Learning Abilities

Is your child aware of other people/activities?
Is your child interested in toys/books?
Is your child easy to motivate?
Attention/ Concentration:
Comments:

## Behaviour

Is your child generally a happy child?
Does your child have more bad days than good days?
Is your child: <ul style="list-style-type: none"><li>a. calm/placid</li><li>b. very active</li><li>c. shy and clinging</li><li>d. demanding</li><li>e. manipulative</li></ul>
Does your child have any special fears that you know of?
Comments:

## Sleeping

Does your child have any sleeping difficulties at night?
Does your child have a rest during the day? When and how Long?
Does your child move in his/her sleep?
Comments:

## Toileting

Is your child clean and dry?  a. during the day b. at night
Does your child wear nappies?
Have you started potty training?
Can your child sit safely on the potty or toilet?
Comments:

## Dressing & Undressing

Does your child take part in dressing & undressing?

Comments:

## Special aids

Piedro boots, AFO, gaiters, arm splint, brace, etc.

Special chair:

Standing frame:

Walking aids:

Other:

Comments:

## Current Treatments

<b>Physiotherapy</b>
PT Name:
Address:
Frequency:
Duration of session:
<b>Speech &amp; Language therapy</b>
SALT Name:
Address:
Frequency:
Duration of session:
<b>Occupational Therapy</b>
OT Name:
Address:
Frequency:
Duration of session:
<b>Portage</b>
Portage worker's name:
Frequency:
Duration of session:
Comments:

## Education

Playgroup/ CDC group etc.
Nursery:
School:
Details of attendance at other centres for specific reason e.g. cranial osteopathy, aromatherapy, reflexology, homeopathy etc.
Comments:

**Please bring all recent reports about your child to your assessment.**

**CEREBRAL PALSY IS A REGISTERED CHARITY (NO. 1041434)**