

**UNITED CEREBRAL PALSY  
STEPS TO INDEPENDENCE®  
INITIAL SCREENING**

**NAME OF CHILD:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE OF CHILD:** \_\_\_\_\_

**PERSON COMPLETING FORM:** \_\_\_\_\_

**DATE FORM COMPLETED:** \_\_\_\_\_

**DIAGNOSIS/HISTORY/EQUIPMENT (SPLINTS/BRACES/WALKERS):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHILD IS CURRENTLY RECEIVING:**

\_\_\_\_ OCCUPATIONAL THERAPY    \_\_\_\_ PHYSICAL THERAPY    \_\_\_\_ SPEECH THERAPY  
\_\_\_\_ CONDUCTIVE EDUCATION    \_\_\_\_ AQUATIC THERAPY    \_\_\_\_ HIPPO THERAPY  
\_\_\_\_ RECREATIONAL SWIMMING    \_\_\_\_ THERAPEUTIC HORSEBACK RIDING    \_\_\_\_ OTHER

**IS YOUR CHILD MOTIVATED BY THINGS AROUND HIM?**

\_\_\_\_ HIGH    \_\_\_\_ GOOD    \_\_\_\_ FAIR (+)    \_\_\_\_ FAIR    \_\_\_\_ FAIR (-)    \_\_\_\_ POOR

**HOW WOULD YOU DESCRIBE YOUR CHILD'S LEVEL OF THINKING?**

\_\_\_\_ AGE APPROPRIATE    \_\_\_\_ MILD DELAY    \_\_\_\_ MODERATE DELAY    \_\_\_\_ SEVERE DELAY

**GROSS MOTOR SKILLS:**

YES    NO

- \_\_\_    \_\_\_    SITS IF SUPPORTED BY EQUIPMENT OR CAREGIVER  
\_\_\_    \_\_\_    SITS UNSUPPORTED ON A CHAIR OR THE FLOOR (POSITION \_\_\_\_\_)  
\_\_\_    \_\_\_    ABLE TO ROLL FROM STOMACH TO BACK OR BACK TO STOMACH  
\_\_\_    \_\_\_    ABLE TO USE ARMS TO PUSH SELF INTO SITTING  
\_\_\_    \_\_\_    ABLE TO COMMANDO CRAWL  
\_\_\_    \_\_\_    ABLE TO GET ON HANDS AND KNEES  
\_\_\_    \_\_\_    ABLE TO CRAWL ON HANDS AND KNEES

- MAINTAINS STANDING POSITION WITH ASSISTANCE  
  MAINTAINS STANDING POSITION INDEPENDENTLY  
  WALKS WITH ASSISTANCE (WALKER, CRUTCHES OR HAND HELD)  
  WALKS INDEPENDENTLY

**FINE MOTOR SKILLS:**

YES    NO

- PLAYS WITH OWN FINGER WHILE ON HIS/HER BACK  
  PATS/SWIPE AT OBJECT  
  GRASPS OBJECTS AFTER REACHING  
  TRANSFERS ITEMS HAND TO HAND  
  ISOLATES FIRST FINGER FOR POINTER POKE  
  CROSSES BODY TO REACH FOR TOY WITH HAND  
  USES WRITING IMPLEMENT  
  USES SCISSORS

**ACTIVITIES OF DAILY LIVING SKILLS:**

**DRESSING SKILLS:**

YES    NO

- PUSHES ARM/LEG THROUGH SHIRT/PANTS  
  UNDRESSES COMPLETELY EXCEPT FOR FASTENINGS  
  PUTS ON T-SHIRT/ PANTS/ SHOES (CIRCLE)  
  MANAGES BUTTONS/ ZIPPER/ SNAPS / TIES SHOE LACES (CIRCLE)

**FEEDING SKILLS:**

ORAL NUTRITIONAL INTAKE:

- ORAL DIET                       G-TUBE OR NG TUBE FEEDING

DIET:

- |  |   |
|--|---|
| <input type="checkbox"/> ALL LIQUIDS       | <input type="checkbox"/> EATS PUREED/BLENDED FOOD |
| <input type="checkbox"/> THICKENED LIQUIDS | <input type="checkbox"/> FORK MASHED              |
| <input type="checkbox"/> NO LIQUIDS        | <input type="checkbox"/> SOFT TABLE FOODS         |
|  | <input type="checkbox"/> ALL TABLE FOODS          |

USE OF UTENSILS:

\_\_\_ FINGER FEED

\_\_\_ USES SPOON WITH CAREGIVERS ASSISTANCE

\_\_\_ USES SPOON WELL

\_\_\_ USES FORK WELL

USE OF DRINKING CONTAINER:

\_\_\_ HOLDS BOTTLE BRINGS TO MOUTH

\_\_\_ HOLDS SPOUT CUP BRINGS TO MOUTH

\_\_\_ HOLDS/LIFTS OPEN CUP WITH TWO HANDS

\_\_\_ HOLDS/LIFTS OPEN CUP WITH ONE HAND

\_\_\_ DRINKS OUT OF A STRAW

**CURRENT AND PREVIOUS THERAPY GOALS:**

PHYSICAL THERAPY:

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OCCUPATIONAL THERAPY:

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SPEECH THERAPY:

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