## Occupational Therapy

## **Teacher Questionnaire**

Child's full name:	Child's date of birth:			
Teacher's name:	School:			
Grade:	Date completed:			
The child's strengths:				
The child's challenges:				
Your main concerns:				
How would you rate the child's posture/muscle dev	velopment?	Good	Average	Weak
How would you rate the child's gross motor skills? coordination, motor planning, ball skills, rhythm)	(Balance,	Good	Average	Poor
How would you rate the child's fine motor skills? (Drawing, colouring, cutting, dressing, etc.)		Good	Average	Poor
How would you rate the child's perceptual skills? (C shapes, letters, building puzzles, etc.)	Colours,	Good	Average	Poor
How would you rate the child's social behaviour?		Good	Average	Poor
How would you rate the child's emotional function	ing?	Good	Average	Poor
Any other comments?				

Thank you very much for taking the time to complete this form.