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Self-Help Skills / Adaptive Behavior Caregiver Checklist

Child's Name: _____ **Age:** _____
Today's Date: _____ **Completed By:** _____

DRESSING

Please use the following scale to rate the items below.

1= Requires total (100%) physical help (Dependent)
2= Tries but needs maximal (75%) physical help
3= Requires moderate (50%) physical help and prompting but completes part of task
4= May require occasional (25%) physical help and prompting, but nearly independent
5= Independent

(Dependent ←---------- ---→Independent)

UNDRESSING	1	2	3	4	5	Resists Task (Y/N)	Comments
Shoes off							
Socks off							
Shirt off (pull over)							
Shirt off (front opening)							
Pants off							
Coat off							
Un-tie shoes							
Follows un-dressing routine							

(Dependent ←----------→Independent)

DRESSING	1	2	3	4	5	Resists Task (Y/N)	Comments
Shoes on							
Socks on							
Shirt on (pull over)							
Shirt on (front opening)							
Pants on							
Coat on							
Tie shoes							
Follows dressing routine							

(Dependent ←----------→Independent)

FASTENERS	1	2	3	4	5	Resists Task (Y/N)	Comments
Open buttons							
Close buttons							
Open snaps							
Close snaps							
Zip up/down							
Engage zipper							

- Is your child resistive during the dressing process? __ Yes __ No
  - If yes, explain:
    _____
    _____
    _____

- Is your child sensitive to certain material/clothing? __Yes __ No
  - If yes, circle all the apply: Tags Socks Jeans Seams
  - Other:
    _____
    _____

- Does child request or demand help even if you've seen him/her complete tasks before?
  __ Yes __ No __ Occasionally

FEEDING

Please use the following scale to rate the items below.

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2= Tries but needs maximal (75%) physical help
3= Requires moderate (50%) physical help and prompting but completes part of task
4= May require occasional (25%) physical help and prompting, but nearly independent
5= Independent

(Dependent ←---------- ----------→Independent)

FEEDING	1	2	3	4	5	Resists Task (Y/N)	Comments
Finger foods							
Uses spoon							
Uses fork							
Drinks from open cup							
Drinks from closed cup							
Spreads with a knife							
Cuts food with a knife							

- Is child resistive during mealtimes? __ Yes __ No __ Sometimes
    - If yes, explain:

_____
_____
_____
_____

- Is child a selective (picky) eater? __ Yes __ No
    - If yes, rate selectiveness: __ Mild __ Moderate __ Significant
    - Preferred foods: (please list)

_____
_____
_____

- Commonly avoided foods: (please list)

_____
_____
_____

- Has your child eliminated foods (used to eat, but now will not) from his/her diet? __Yes __No
    - If yes, explain:

_____
_____
_____

- Do you prepare a different meal for your child than for the rest of the family?
  __Never __Rarely __Occasionally __Frequently __Always

- How would you rate the mealtime stress level at your home?
  __Not typically stressful __Minimal __Moderate __Significant

PERSONAL HYGIENE

Please use the following scale to rate the items below.

1= Requires total (100%) physical help (Dependent)
2= Tries but needs maximal (75%) physical help
3= Requires moderate (50%) physical help and prompting but completes part of task
4= May require occasional (25%) physical help and prompting, but nearly independent
5= Independent

(Dependent ←----------→Independent)

TOILETING	1	2	3	4	5	Resists Task (Y/N)	Comments
Initiates toileting							
Manages clothing							
Wipes self							
Hand washing							
Sequencing task							
Bathroom mobility							

(Dependent ←----------→Independent)

HYGIENE	1	2	3	4	5	Resists Task (Y/N)	Comments
Tooth brushing							
bathing							
Washing hair							
Brush/comb hair							
Apply deodorant							
Nail Clipping							
Ear Cleaning							

- Does your child prefer Shower or Bath __ Shower __ Bath
- Is your child resistive during bathing? __ Yes __ No
- Is your child resistive during tooth brushing? __ Yes __ No
- Is your child completely independent w/ toileting? __ Yes __ No

If NO, __ toilet trained but needs help wiping
__ 'accidents' during the day (bladder / bowel)
__ 'accidents' during the night (bladder / bowel)
__ has started potty training
__ is showing 'readiness signs' of toilet training
__ has not started potty training

SLEEPING HABITS

(circle one)

- Does your child sleep through the night? **Always Usually Sometimes Rarely Never**
- Does your child wake up during the night? **Always Usually Sometimes Rarely Never**
- Does your child have difficulty "winding down" at night? **Always Usually Sometimes Rarely Never**
- Does your child follow a bedtime routine consistently? **Always Usually Sometimes Rarely Never**
- Does your child seem "rested" in the morning? **Always Usually Sometimes Rarely Never**
- Is your child difficult to "get going" in the morning? **Always Usually Sometimes Rarely Never**
- Does your child sleep in his/her own room? **Always Usually Sometimes Rarely Never**
  - If not, where does your child sleep? _____
  - How many nights per week does your child sleep somewhere other than his/her room? _____

ADDITIONAL COMMENTS / CONCERNS:

What areas of Self-Help/Adaptive Skills would you like to address in therapy?

Additional Comments: