DEVELOPMENTAL SCREENING

CHILD'S NAME: _____

DATE OF BIRTH:_____

PARENT OR GUARDIAN: _____

DATE:_____

Please check all of the items your child can do. At the bottom please list any concerns you have about your child's development.

****MOVEMENT**

____ Stands on one foot for 10 seconds or longer
____ Hops, somersaults
____ Swings, climbs
____ May be able to skip

****MILESTONES IN HAND AND FINGER SKILLS**

____ Copies triangle and other geometric patterns
____ Draws person with body
____ Prints some letters
____ Dresses and undresses without assistance
____ Uses fork, spoon
____ Usually cares for own toilet needs

****LANGUAGE MILESTONES**

____ Recalls parts of a story
____ Speaks sentences of more than 5 words
____ Uses future tense
____ Tells longer stories
____ Says name and address

**** COGNITIVE MILESTONES**

___ Can count 10 or more objects
___ Correctly names at least 4 colors
___ Knows about things used every day in the home (money, food, etc.)

****SOCIAL MILESTONES**

___ Wants to please and be with friends
___ More likely to agree to rules
___ Likes to sing, dance, and act
___ Shows more independence

****Please List Any Concerns you have with your child`s development:**

_____

_____

Please feel free to use the back!