



London N. Breed, Mayor
Philip A. Ginsburg, General Manager

Leisure Interest and Functional Abilities Assessment

Participant Information

Participants name _____ School attended _____

Date _____ Age _____ DOB _____ (Please Circle) R or L handed?

Parent/Legal Guardian _____

Relationship to participant _____

Address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____

Emergency contact _____ Phone _____

Relationship to participant _____

Please check all that apply and add any comment:

ADD ADHD Autism Cystic Fibrosis
 ODD OCD PDD-NOS Down syndrome
 TBI Cerebral Palsy Ataxia Development Delay
 Anxiety Prader Willi Fatigue Chiari Malformation
 Celiac Disease Aspergers Depression
Other _____

Understanding the participant has of checked response/Comments _____

Medical Information: Please check all that apply to the participant.

Tube feeding Diabetes Ear Tubes Allergies
Asthma High Blood Pressure Hearing Aids Gluten Free Diet
Catheterization Vagus Nerve Stimulator Glasses Latex Allergy





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Other _____

Medications:

Name: _____ Treatment for _____

Dosage _____ Time _____ Possible Side Effects _____

Name: _____ Treatment for _____

Dosage _____ Time _____ Possible Side Effects _____

Name: _____ Treatment for _____

Dosage _____ Time _____ Possible Side Effects _____

Behavior: Please mark if your child exhibits any of the following behaviors and please give an example.

- Runs away from the group
- Inappropriate touch/self/others
- Inappropriate language
- Biting
- Self Injurious behaviors
- Aggression
- Tantrums (Meltdowns)

Examples

What has been most effective in avoiding or managing these behaviors?

Sensory Processing: Please check and comment.

<input type="checkbox"/> Noises	_____	Climbing	_____
<input type="checkbox"/> Balance	_____	Jumping	_____
<input type="checkbox"/> Light touch	_____	Head Phones	_____
<input type="checkbox"/> Squeezing	_____	Vestibular	_____
<input type="checkbox"/> Swinging	_____	Proprioceptive	_____
<input type="checkbox"/> Smells	_____	Taste	_____
<input type="checkbox"/> Transitions	_____	Tactile	_____





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___ Other _____

Please place a check next to the one best statement that applies to participant and comment if necessary. Thanks!

1. Wheelchair users only (other skip to #2)

- ___ Uses a wheelchair and needs total assistance with mobility
- ___ Uses a wheelchair and needs assistance with transfers
- ___ Is independent with wheelchair mobility

Comment _____

2. Mobility

- ___ Walks with total physical assistance
- ___ Walks with some assistance
- ___ Walks independently

Comment _____

3. Dressing (pulls pants down to go to toilet , put on clothes)

- ___ Needs total assistance
- ___ Needs some physical assistance or verbal prompting
- ___ Dresses/undresses independently

Comment _____

4. Eating/Drinking

- ___ Needs total assistance (please comment)
- ___ Needs some physical assistance, verbal prompting or supervision
- ___ Eats/drinks independently

Comment _____

5. Toileting

- ___ Incontinent and uses pull-ups or other
- ___ Needs to be reminded, supervision, or is on a bathroom schedule
- ___ Asks and goes independently

Comment _____





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6. Communication

- Unable to communicate wants or needs
- Communicates with gestures, some words, PECS, or sign language
- Verbally communicates independently

Comment _____

7. Receptive Skills

- Recognizes own name when called
- Responds to simple one step requests
- Responds to a request in a small group

Comment _____

8. Social Interaction

- Demonstrates minimal or no awareness of others
- Needs prompting to initiate interaction
- Will initiate interaction with others independently

Comment _____

9. Group Interaction Skills

- Does not interact with others in a group
- Needs prompting to play with others in small groups
- Is able to participate in simple group games

Comment _____

10. Attention

- Needs assistance during all activities
- Can engage in an activity for at least fifteen minutes with some prompting
- Can engage independently in an activity for a least fifteen minutes

Comment _____

11. Personal Awareness

- Needs total assistance with personal belongings





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- Needs verbal prompting to assist with personal belongings
- Able to identify and take responsibility for personal belongings

Comment _____

12. Gross Motor Skills

- Needs total assistance to participate in physical activities
- Needs some assistance to participate in physical activities
- Can walk or run independently

Comment _____

13. Following Directions

- Wanders or runs from groups (please comment)
- Has difficulty with verbal directions
- Stays with the group and can follow simple directions

Comment _____

14. Swimming

- Non-swimmer, requiring individual attention in water
- Uses a floatation device (Please identify: vest)
- Able to swim short distances

Comment _____

15. Managing Behaviors

- Is unresponsive and unable to follow directions
- Can "take a break" and manage behavior with assistance
- Able to self calm with verbal assistance

Comment _____

16. Please identify situations or circumstances that might trigger an outburst or other problem behavior and describe the behavior.

17. Please identify any behavior management techniques used at home or other settings that will encourage positive behaviors or discourages problem behaviors.





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18. How does the participant respond to physical contact?(hugging, hi-fives)

19. Please identify participant's strengths. (Games, imagination, sports, computer, gets along well with friends, etc)

20. Current Activity Level:

Activities done alone _____

Activities done with family _____

Activities done with organizations _____

To be completed by staff:

Recreation Goals: Increase communication, improve motor skills/endurance, introduce to new activity, encourage play with others, etc

1. _____
2. _____
3. _____





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Evaluator

Date

