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**Special Needs Child Assessment and Therapy Plan Form**

**1. Basic Information**

* **Child's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Gender:** ☐ Male ☐ Female ☐ Other
* **Date of Assessment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Assessor’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Diagnosis**

* **Has the child been diagnosed with any condition?**
☐ Yes ☐ No
If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Diagnosis made by (name of specialist/professional):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Current Medications (if any):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Medical and Developmental History**

* **Were there any concerns during pregnancy or birth?**
☐ Yes ☐ No
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Has the child had any major illnesses or surgeries?**
☐ Yes ☐ No
If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Sensory Needs**

* **Does the child display sensory sensitivities or seek sensory input?**
☐ Yes ☐ No
If yes, please specify (e.g., touch, sound, light, movement):
* **What sensory preferences or aversions does the child have?**
	+ Prefers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Avoids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Any specific tools or strategies used to manage sensory needs?**
☐ Weighted blanket ☐ Noise-canceling headphones ☐ Visual aids ☐ Fidget toys
☐ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Communication and Social Skills**

* **How does the child communicate?**
☐ Verbally ☐ Non-verbally ☐ Uses communication device ☐ Sign language
☐ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Does the child interact with others (family members, peers)?**
☐ Yes ☐ No
If yes, how: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Does the child have difficulty understanding social cues?**
☐ Yes ☐ No

**6. Behavioral Patterns**

* **Does the child exhibit any challenging behaviors (e.g., aggression, self-injury)?**
☐ Yes ☐ No
If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Are there any known triggers for these behaviors?**
☐ Yes ☐ No
If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Parents' and Caregiver's Expectations**

* **What are your main goals or concerns for the child’s therapy?**
* **Are there specific areas you would like the therapy to focus on?**
☐ Communication ☐ Behavior management ☐ Sensory regulation
☐ Social skills ☐ Fine/gross motor skills ☐ Self-care skills ☐ Other: \_\_\_\_\_\_\_\_
* **What do you hope the child will achieve in the next 6 months?**

**8. Carer’s Input**

* **What are your expectations from the therapy process?**
* **Are there any challenges you face in supporting the child’s needs?**

**9. Therapy Plan (to be filled by the therapist)**

* **Short-term therapy goals (next 3 months):**
* **Long-term therapy goals (next 6-12 months):**
* **Therapeutic approaches to be used:**
☐ Speech therapy ☐ Behavior therapy ☐ Physical therapy
☐ Sensory integration therapy ☐ ABA therapy ☐ Pressure ☐ other:\_\_\_\_\_\_\_\_
* **Frequency of sessions:**
☐ 1x per week ☐ 2x per week ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Home strategies for parents/carers:**
* **Review date for progress:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. Additional Notes**

This form is comprehensive, yet you can always adapt it to fit specific contexts or needs. Let me know if you’d like any further customization!

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