
HANDWRITING CAMP INTAKE FORM

Child's Name: _____

DOB (mm/dd/yy): _____

Grade: _____

Child's School: _____

Guardian Name: _____

Address: _____

Email: _____

Cell Phone: _____

Guardian Name: _____

Address: _____

Email: _____

Cell Phone: _____

Allergies (please list): _____

Known medical issues or diagnoses: _____

Does your child have an IEP? YES / NO

If yes, please share services and your goals: _____



222 Main Street
Acton, MA 01720
978-287-7878

Concerns regarding handwriting and additional information you would like us to know: _____

Please answer the following regarding your child:

Good seated posture YES/NO Able to write their name YES/NO

Know *LEFT* from *RIGHT* YES/NO Know *TOP* from *BOTTOM* YES/NO

Able to scribble or color YES/NO Reverse letters or numbers YES/NO

Work age appropriate puzzles YES/NO

Does your child wear eyeglasses? YES/NO

Have age appropriate grasp with writing utensil: YES/NO /DON'T KNOW

Too strong a grasp with writing utensil YES/NO

Too weak a grip with writing utensil YES/NO

Does your child know their major body parts: YES/NO

Has your child received handwriting services before? YES/NO

If yes, where and the name of the handwriting program if known: _____

Thank you for taking the time to complete this form and we look forward to working with your children!

The Staff at Extra Steps Pediatric Therapies, Inc.
info@extrasteps.org

<https://minutemanarc.org/programs/extra-steps-pediatric-therapies/>