



Parent Goal-Setting Form

Child: _____

Date: _____

1. Tell us about your child. What are his/her gifts/strengths?

2. What is your child's typical day like? What challenges does he/she have in: **(use the back of this page to answer this question.)**

- a. Waking up
- b. Getting dressed
- c. Eating breakfast
- d. Brushing teeth
- e. Getting into car or transitioning to bus for school
- f. Other functional daily tasks?

3. Let's pretend you are sitting here now. What are a few changes that you would like to see in your child? Please be specific and consider that they might be in therapy for at least 3-4 months.

a.

b.

c.

Name of person completing form _____

Relationship to Child _____