Advanced Therapy Solutions

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__________________

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