



SCHOOL FOR AUTISTICALLY IMPAIRED LEARNERS, S.A.I.L.

CHILD'S NAME _____

DATE _____

T.I.D.E.S. (Therapists Individual Documentation and Evaluation of Student)©

Document skills according to frequency of use. 1 = Skill not used 2 = Skilled used some 3 = Skill used

OCCUPATIONAL THERAPY	1	2	3	Comments:
1. Gross motor skills				
2. Fine motor skills				Therapist Signature:
SPEECH-LANGUAGE-COMMUNICATION	1	2	3	Comments:
1. Verbalizes wants and needs				
2. Indicates wants and needs				
3. Utilizes gestures/pictures to communicate				
4. Follows simple directions				
5. Approximates/imitates correct mouth and tongue positioning				
6. Attends/complete speech tasks				Therapist Signature:
SENSORY INTEGRATION	Comments			
1. Vestibular				
2. Proprioception				
3. Tactile				
4. Auditory				
5. Visual				
6. Oral-Motor				
	Therapist Signature:			
MUSIC THERAPY	Independently	With Assistance	Comments:	
1. Able to pass instruments appropriately to others				
2. Able to focus & attend to music interventions				
3. Moves/dances to the beat of music				
4. Plays instruments				
5. Vocalizes appropriately during music			Therapist Signature:	
ART THERAPY	Independently	With Assistance	Comments:	
1. Waiting for directions, i.e., Receptive Language				
2. Eye Gaze Stability				
3. Gross Motor Ability, i.e., sitting				
4. Fine Motor Ability, i.e, cutting, painting, coloring				
5. Following Directions of Therapist				
6. Utilization of Expressive Language			Therapist Signature:	