



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:	

