ORIENTATION AND MOBILITY CHECKLIST
BIRTH-2 Years

Student:_____ Contact Person:_____ Phone#_____

The student: Has vision?__ Has light perception? __ Has no vision?__
Travels independently?__ Walks __ Crawls __ Creeps __ Scoots __ Rolls __
Has had previous O&M training? ___ yes ___ no
Wears glasses or uses visual aids? ___ yes ___ no
Follows simple commands? (stop, come here) ___ yes ___ no
Uses walker __ wheelchair __

Home	Always	Sometimes	Never
Student:			
● Turns toward environmental sounds	____	____	____
● Responds positively to textures	____	____	____
● Rolls over	____	____	____
● Reaches for objects	____	____	____
● Sits independently	____	____	____
● Pulls to a standing position	____	____	____
● Stands with support	____	____	____
● Supports body on hand/knees	____	____	____
● Stands without support	____	____	____
● Locates object visually and moves toward it	____	____	____
● Moves toward sound producing toy	____	____	____
● Moves from room to room independently	____	____	____

Identifies basic body parts?(circle all that apply): head, nose, ear, mouth, arm, finger, hands, leg, toes, cheeks, chin, neck, shoulders, back , thumb, ankle

Problem Areas

___ Difficulty negotiating play equipment
___ Bumps into objects and people
___ Trouble adjusting to light changes
___ Difficulty with surface changes
___ Walks without regard to own safety
___ Difficulty with steps, stairs, etc.
___ Trouble with glare/shadow
___ Other?

COMMENTS:_____

_____