YOUR LOGO
(optional)

CLINIC / PRACTITIONER NAME

Form OT-ASD-01

Address · phone · license #

Occupational Therapy Assessment — Autism

Sensory, regulation, and daily participation assessment for autistic children and adults.

CLIENT INFORMATION

Client name

Date of birth

Age

Date of assessment

Parent / guardian / support person

Phone / email

School / program / workplace

Date of diagnosis

Co-occurring diagnoses

COMMUNICATION & SUPPORT

Primary communication method

Support needs / level

Known triggers

Effective calming strategies

SENSORY SYSTEM	SEEKS	AVOIDS	RESPONSE & OBSERVATIONS

Systems: tactile · vestibular · proprioceptive · auditory · visual · oral / taste · smell · interoception

DAILY PARTICIPATION — check areas of difficulty

- ☐ Dressing
- ☐ Bathing & grooming
- ☐ Play & leisure
- ☐ Peer & social interaction
- ☐ Feeding / mealtimes
- ☐ Sleep routines
- ☐ School / work routines
- ☐ Handwriting / fine motor
- ☐ Toileting
- ☐ Transitions between activities
- ☐ Community outings
- ☐ Motor coordination

Self-regulation, behaviour & environmental observations

Strengths, interests & motivators

Recommendations, accommodations & goals

ADDITIONAL NOTES

Continuation, observations, or notes

SIGNATURES

This assessment was completed by a licensed occupational therapist in collaboration with the client and their support people.

Therapist signature (OTR/L)

Date

Parent / guardian / client signature

Date