YOUR LOGO
(optional)

CLINIC / PRACTITIONER NAME

Form OT-EVAL-01

Address · phone · license #

Occupational Therapy Evaluation

Initial / comprehensive evaluation — occupational profile, performance measures, assessment, and plan.

CLIENT INFORMATION

Client name

Date of birth

Medical record # / ID

Date of evaluation

Referring provider

Diagnosis / ICD-10

Precautions & contraindications

Occupational profile — client priorities, roles, routines, and environment

AREA	LEVEL OF ASSIST	DEVICE / ADAPTATION	COMMENTS

Assist key: I = independent · S = supervision · MinA / ModA / MaxA · D = dependent

MEASURE	RIGHT	LEFT	NOTES

COGNITION, VISION & SENSATION

- ☐ Orientation intact
- ☐ Attention concerns
- ☐ Memory concerns
- ☐ Problem solving concerns
- ☐ Safety awareness concerns
- ☐ Visual acuity concerns
- ☐ Visual field cut
- ☐ Neglect present
- ☐ Sensation intact
- ☐ Sensation impaired
- ☐ Pain reported
- ☐ Fatigue limits participation

Assessment / clinical impression

#	GOAL STATEMENT	BASELINE	TARGET	TARGET DATE

PLAN

Frequency

Duration

Setting

Recommended interventions

SIGNATURES

This evaluation was completed by a licensed occupational therapist and reviewed with the client or their representative.

Therapist signature (OTR/L)

Date

Client / caregiver signature

Date