YOUR LOGO
(optional)

CLINIC / PRACTITIONER NAME

Form OT-PEDS-01

Address · phone · license #

Pediatric Occupational Therapy Evaluation

Developmental, sensory, and participation evaluation for children and their families.

CHILD INFORMATION

Child's name

Date of birth

Chronological age

Date of evaluation

Parent / guardian

Phone / email

School / program

Referral source

Diagnosis / concerns

Birth, medical & developmental history

Parent / caregiver concerns and priorities

MILESTONE	AGE ACHIEVED	TYPICAL RANGE	NOTES

SENSORY PROCESSING OBSERVATIONS

- ☐ Tactile seeking
- ☐ Tactile avoiding
- ☐ Vestibular seeking
- ☐ Vestibular avoiding
- ☐ Proprioceptive seeking
- ☐ Auditory sensitivity
- ☐ Visual sensitivity
- ☐ Oral seeking / avoiding
- ☐ Difficulty with transitions
- ☐ Self-regulation difficulty
- ☐ Motor planning difficulty
- ☐ Fatigues quickly

ASSESSMENT	DATE	SCORE	INTERPRETATION

Play, self-care & school participation

Clinical impression & summary

#	GOAL STATEMENT	BASELINE	TARGET DATE

SIGNATURES

This evaluation was completed by a licensed occupational therapist and reviewed with the family.

Therapist signature (OTR/L)

Date

Parent / guardian signature

Date