

OCCUPATIONAL THERAPY
INITIAL EVALUATION

Client Name: _____ Medicare # _____

Diagnosis: _____ Onset: _____

Medical Hx: _____

Precautions: _____

Referring Physician: _____ Referral Date: _____ Date: _____

OCCUPATIONAL PROFILE:

What problems and concerns do you have regarding performing your daily occupations? _____

A typical day consists of: _____

Client lives ☐ with ☐ alone _____ in a ☐ house ☐ trailer ☐ apt. with _____ steps to enter ☐ R/ ☐ L handrail; _____ stories; _____ steps inside home _____

What occupations do you currently need assistance with? _____

Did you need assistance with these occupations previously? _____

What occupations do you participate in for fun and how often (Culture, leisure, social)? _____

What motivates you to improve? _____

How are you coping with your current status? _____

What is your preferred learning style? _____

What goals do you/your family have? _____

DRESSING	INDEP	SBA	MIN. ASSIST	MOD. ASSIST	MAX. ASSIST	ADAPT. EQUIP.	COMMENTS/ADAPTIVE EQUIPMENT ISSUED
Put on & remove the following							
front opening shirt							
pull on shirt							
underwear							
bra							
pants/slacks							
socks/hose							
shoes							
manage fasteners							
braces/splints/prosthesis							
GROOMING/HYGIENE							
sponge bath							
tub/shower bath							
shave							
comb hair							
brushing teeth							
opens jars/bottles							
make-up							
EATING							
drink from cup/glass							
feeds self							
cuts meat							

ROM				UPPER EXTREMITY ROM & STRENGTH		
ACTIVE LEFT	PASSIVE LEFT	ACTIVE RIGHT	PASSIVE RIGHT		L	R
				SHOULDER: Elevation		
				Flexion		
				Abduction		
				Horizontal Abduction		
				Horizontal Adduction		
				Internal Rotation		
				External Rotation		
				ELBOW: Flexion		
				Extension		
				Supination		
				Pronation		
				WRIST: Flexion		
				Shoulder Subluxation	L	R
				UE Edema	L	R
				Pain	L	R

ORIENTED TO:		
Person _____	Place _____	
Time: Month _____	Day _____	Year _____
Situation _____		
COMMUNICATION/COGNITION		
	YES	NO
Verbal		
Understandable		
Appropriate		
Perseveration		
Follows Simple Commands		
Reads		
Writes		

PERCEPTION		
A. R/L Neglect _____	Impaired	WFL
B. Body Schema		
C. Discrimination		
Shape		
Size		
Color		
D. Visual Perception		
R/L Discrimination		
Spatial Relations		
Overall Endurance	WFL	
	Fair	
	Poor	

PERSONAL DEVICES:				
Wears glasses _____	Dentures _____	Hearing _____		
MUSCLE TONE/UPPER EXTREMITIES				
Hypotonic _____	Normal _____	Hypertonic _____		
Comments _____				
UPPER EXTREMITY SENSATION				
Light touch				
Sharp/Dull				
Temperature				
Proprioception				
Stereognosis				
COORDINATION/UPPER EXTREMITIES				
Tremors _____	Apraxia _____	Ataxic _____	Impaired	WFL
Gross Motor				
Fine Motor				
9-Hole Peg Test		L		R
Grip Strength		L		R
Lateral Pinch		L		R
Tripod Pinch		L		R
Hand Dominance		L		R
IADLs	Indep.	Min. Assist	Mod. Assist	Max. Assist
Phone Book Usage				
Money Mngmt.				
Situation Problem Solving				
Homemaking				

Long/Short Term Goals: _____

Therapist: _____

Date: _____