OT Evaluation

Patient Name: Date of Birth:

Areas of Concern

- Diagnosis
- Activity Restrictions
- Limitations
- Behaviors

Birth History

- Complications with pregnancy and/or delivery
- Full term or pre-term

Developmental Milestones

At what age did they…

- Roll
- Sit
- Crawl
- Walk

Recent illnesses, hospitalizations, or surgery

Current Medications

_____

_____

_____

Allergies

☐ None

☐ Yes: _____

Vision & Hearing

- Date last tested:
- Normal/concerns

Any adaptive equipment?

History of Therapy

- Have they received services before?
- Type
- Duration
- Time since last services

Home Environment

- Stairs / # of stories
- Who do they live at home with?

School

- Grade
- IEP?

ADLs	Level of Independence		
	Unable	Requires Help	Independent
Dressing ▪ Socks ▪ Shoes ▪ Shirt			
Fasteners ▪ Buttons ▪ Zippers ▪ Laces			
Bathing			
Toileting			
Brushing Teeth			
Brushing Hair			
Self-feeding ▪ Utensils			