Occupational Self Assessment (OSA)

Patient Information
Name:
Date of Assessment:
Therapist's Name:

Instructions: Please rate your perceived competence in performing the following activities and the importance or value you place on each activity. Use the following scales for your responses:

- **Competence:** 0 (Cannot do it) to 4 (Can do it well)
- **Value:** 0 (Not important to me) to 4 (Extremely important to me)

Activities

1. Personal Care (e.g., bathing, dressing)

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

2. Meal Preparation and Cleanup

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

3. Household Management (e.g., cleaning, laundry)

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

4. Shopping and Community Mobility

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

5. Work or School Tasks

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

6. Leisure Activities (e.g., hobbies, sports)

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

7. Social Participation (e.g., spending time with friends/family)

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

8. Financial Management

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

9. Health Management and Maintenance

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me

10. Other Activities

Please specify: _____

Competence:

0. Cannot do it	1.	2.	3.	4. Can do it well
○	○	○	○	○

Value:

0. Not important to me	1.	2.	3.	4. Extremely important to me
○	○	○	○	○

Client's Comments and Observations

Any additional notes or comments regarding the assessment or specific activities.

Therapist's Use

Date of Review
Summary of Assessment
Identified Goals and Priorities
Planned Interventions