Occupational Therapy Goals

Client Information		
Name:	Age:	
Diagnosis/Condition:	Date of Initial Evaluation: / /	
Referring Physician/Healthcare Provider:		
Initial Evaluation Findings		
1. Physical/Motor Skills:		
2. Cognitive/Perceptual Skills:		
3. Psychosocial/Emotional Skills:		
4. Activities of Daily Living (ADLs):		
5. Instrumental Activities of Daily Living (IADLs)		

Long and Short-Term Goals
Long-Term Goal 1:
Short-Term Goals 1:
Long-Term Goal 2:
Short-Term Goals 2:
Long-Term Goal 3:
Short-Term Goals 3:
Intervention Plan
1. Frequency and Duration of Sessions:
2. Therapeutic Approaches/Techniques:
3. Equipment and Adaptive Devices:
4. Environmental Modifications:
5. Collaboration with Other Professionals:

Discharge Plan
1. Criteria for Discharge:
2. Follow-up Recommendations:
3. Home Exercise Program:
4. Community Resources:
Progress Notes
Progress Notes 1. Date:
1. Date:
Date: Subjective Information:
1. Date: 2. Subjective Information: 3. Objective Observations:

Therapist's Acknowledgment		
Name:		
Signature:		
Date Signed:		
Client/Guardian's Acknowledgment		
Name:	Relationship to Client:	
Signature:	Date Signed:	