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
1. Date:
2. Subjective Information:
3. Objective Observations:
4. Assessment:
5. Plan/Interventions:
6. Goals Addressed:

Additional Notes

Therapist’s Acknowledgment
Name:
Signature:
Date Signed:

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