

Occupational Therapy Instrumental Activities of Daily Living (IADLs) Evaluation

Evaluation Information

Date of evaluation:

Client name:

Client age:

Client History

Background:

Is the client currently receiving therapy services or has the client received therapy services in the past?

Yes No

If yes, please explain therapy history, type, and goals addressed:

Medical history:

Does the client have a diagnosis?

Yes No Unsure

If yes or unsure, please provide more details:

Current concerns:

Behavior and engagement during occupational therapy evaluation:

Instrumental Activities of Daily Living (IADLs)

Care of others (including selection and supervision of caregivers)

Care of pets and animals

Communication management

Driving and community mobility

Financial management

Home establishment and management

Meal preparation and cleanup

Religious and spiritual expression

Safety and emergency maintenance

Shopping

Assessment Summary

Observations and impressions:

Justification for treatment:

Interpretation of results:

Goals

Goal #1

Goal:

Baseline:

Goal #2

Goal:

Baseline:

Goal #3

Goal:

Baseline:

Goal #4

Goal:

Baseline:

Goal #5

Goal:

Baseline:

Recommendations

Frequency of therapy:

Home program:

Other information: