Occupational Therapy Pediatric Evaluation

Evaluation Details		
Date:	**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:		

Attention and Engagement *If checked, please provide more details:*	
☐ Able to attend to task	☐ Able to complete a 1-step task
☐ Able to complete a 2-step task	☐ Able to complete a multiple step task
Additional comments:	

Attention and Engagement *If checked, please provide more details:*		
☐ Stack blocks	☐ Open a twist top container	☐ Thread beads
☐ Hold and use scissors	☐ Hold and use a pencil	**Additional comments:**

Visual Motor Skills *If checked, please provide more details:*	
☐ Imitate block designs	☐ Imitate shapes
☐ Imitate pre-writing strokes	☐ Cut shapes
☐ Write name	**Additional comments:**

Self-Care and Activities of Daily Living (ADLs) *If checked, please provide more details:*		
☐ Dressing	☐ Eating and feeding	☐ Hygiene
☐ Bathing	☐ Toileting and toilet hygiene	**Additional comments:**

Sensory Integration *If checked, please provide more details:*	
☐ Auditory	☐ Olfactory
☐ Oral	☐ Proprioceptive
☐ Tactile	☐ Vestibular
☐ Visual	**Additional comments:**

Primitive Reflexes *If checked, please provide more details: ex. Integrated, present, or any comments*		
☐ ATNR	☐ Moro Reflex	☐ Palmer Reflex
☐ Spinal Galant	☐ STNR	☐ TLR
Additional comments:		

School Engagement	
Is child receiving therapy in the school setting? ☐ Yes ☐ No	
If yes, what kind?	*If yes, please specify how often and any additional comments per type of therapy:*
☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ Behavioral Support ☐ School Psychology: ☐ Other:	
Additional comments:	

Standardized Assessments *Please provide results:*
Fine Motor / Visual Motor Standardized Assessments
Beery-Buktenica Developmental Test of Visual Motor Integration, 6th Edition:
Developmental Test of Visual Perception, Third Edition:
Developmental Standardized Assessments
Peabody Developmental Motor Scales, Second Edition:
Gross Motor Standardized Assessments
Bruininks-Oseretsky Test of Motor Proficiency, Second Edition:
Sensory Standardized Assessments
Sensory Profile 2:
Sensory Processing Measure:

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: