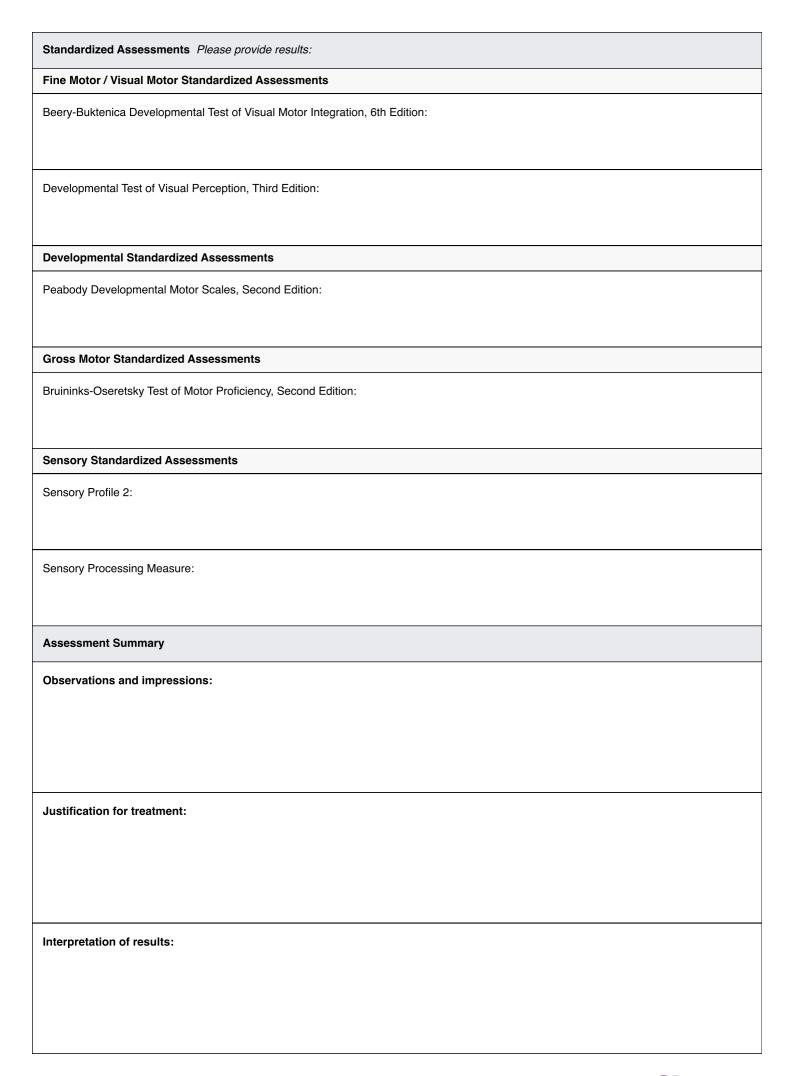
Occupational Therapy Pediatric Evaluation

Evaluation Details				
Date:	Client name:	Client age:		
Client History				
Background:				
Is the client currently receiving therapy ser	vices or has the client received therapy servio	ces in the past? U Yes U No		
If yes, please explain therapy history, type, and	d goals addressed:			
Medical History:				
Does the client have a diagnosis? U 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 co	ontainer	Thread beads		
Hold and use scissors	□ Hold and use a pencil		Additional comments:		
Visual Motor Skills If checked, please provid	le 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	Dressing Eating and feeding		□ Hygiene		
□ Bathing	Toileting and toilet hygiene		Additional comments:		

Sensory Integration If checked, please provide more details:					
		Olfactory			
Oral		Proprioceptive			
Tactile		Vestibular			
Visual	□ Visual		Additional comments:		
Primitive Reflexes If checked, please provide more details: ex. Integrated, present, or any comments					
	□ Moro Reflex		Palmer Reflex		
Spinal Galant			□ TLR		
Additional comments:					
School Engagement					
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:					



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:			