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:	