

# Occupational Therapy Treatment Plan

## Client Information

Name:

Date of Birth:

Address:

Phone Number:

Emergency Contact:

Referring Physician:

Date of Initial Evaluation:

## Medical and Therapy History

Primary Diagnosis:

Secondary Diagnosis:

Previous Therapies and Outcomes:

Relevant Surgical History:

Medications:

Allergies:

## Assessment Summary

Cognitive Function:

Physical Abilities:

Sensory Functions:

Emotional / Behavioral State:

Communication Skills:

Social Skills:

Environmental Factors:

Activities of Daily Living (ADLs) Performance:

Instrumental Activities of Daily Living (IADLs) Performance:

**Goals**

Short-Term Goals:

Long-Term Goals:

**Intervention Plan**

Therapeutic Activities:

**Adaptive Techniques and Equipment**

**Environmental Modifications**

**Caregiver / Family Training**

**Implementation Schedule**

**Progress Review and Modifications**

**Discharge Planning**

Achievements:

Recommendations for Continued Care:

Follow-up Appointments:

**Professional's Signature**

Name:

Title:

Date:

**Client / Caregiver Acknowledgement**

Name:

Relationship to Client:

Date: