**OCCUPATIONAL THERAPY EVALUATION**

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| ***Name of Patient:*** | ***DOB:*** |
| ***Name and relationship of person completing this form:*** | ***Age:*** |
| ***Phone:*** | ***Current School:*** |
| ***Home Address:*** | ***School/Daycare, Grade:*** |
| ***Teacher:*** |
| ***Insurance:*** | ***Approved visits (****office use):* |
| ***Policy#:*** | ***Expiration date of visits(****office use)****:*** |
| ***Referring Doctor (name and phone number):*** | ***Comments:*** |

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| **MOTHER’S PRENATAL HISTORY** | | |
| **Was the pregnancy full term?: yes/ no**  **If no, at how many weeks was the child born?** | | **Where there any complications during the pregnancy? (***if yes, please explain)?* |
| **Did the patient need to stay in the NICU? :** *(if yes, why and how long)* | |
| **Where there any complications during birth?:** *(if yes, please explain)* | | **Other:** |
| **PATIENT’S HEALTH HISTORY** | | |
| **Child’s diagnosis (if any):** | **Reason for referral**: | |
| **List any medications the child is currently on:** | **List any services the child received in the past:** | |
| **Current functional level:** *(circle one for each category)*  ***Self-dressing*** *(circle level of assistance)*   * Puts pants on/off (*Ind, ModA, MaxA)* * Puts shoes on/off (*Ind, ModA, MaxA)* * Puts socks on/off (*Ind, ModA, MaxA)* * Puts shirt on/off (*Ind, ModA, MaxA)* * Puts coat on/off (*Ind, ModA, MaxA)* * Buttons/Zippers pants/coats (*Ind, ModA, MaxA)* * Ties shoes (*Ind, ModA, MaxA)*   *\*\*\*Independent=Ind, Moderate Assistance=ModA, Maximum Assistance = MaxA* | **Current functional level:** *(circle one for each category)*  ***Self-feeding***   * Uses spoon, fork (*Ind, ModA, MaxA)* * Uses bottle/sippy cup/cup (*Ind, ModA, MaxA)*   ***Grooming***   * Washes hands(*Ind, ModA, MaxA)* * Brushes own hair/teeth (*Ind, ModA, MaxA)* * Uses bathroom (*Ind, ModA, MaxA)*   **Other concerns:** *(coloring, cutting, handwriting, sensory, attention)* | |
| **List 3 most important goals for the child:**  1  2  3 | **Comments:** | |