**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:**123 | **Comments:**  |