[Company Name]
Outpatient Occupational Therapy Evaluation

Patient Name	**Physician Name**
Diagnosis	**Date of Onset**
Medications/Allergies/Precautions	
Past Medical History	
Subjective	

Physical Assessment

Speech:	Vision:	Hearing:	Cognition:
Nutritional Screening:	Appearance: Well-Nourished ☐ Yes ☐ No	Well-Hydrated ☐ Yes ☐ No	
	Recent Weight: ☐ Loss ☐ Gain Amount:		
	Special Diet:		
Pain:			
Upper Extremity Range of Motion:			
Strength (MMT/Grip/Pinch):			
Hand Dominance: ☐ Left ☐ Right Coordination:			
Proprioception:			
Tone:			
Edema/Skin Integrity:			

Sensation:	
ADL's (Dressing/Hygiene/Toileting/Mobility/Home Skills/Leisure):	
Vocation/Vocational Skills:	
Adaptive Equipment Owned:	Needs:
Splints Owned:	Needs

Assessment:

Rehab Potential: ☐ Excellent ☐ Good ☐ Fair	Barriers to Learning:

Short-Term Goals:

Long-Term Goals:

Plan of Treatment:

☐ Manual Therapy	☐ Therapeutic Exercise	☐ Balance Training
☐ Neuromuscular Re-Education	☐ Neurologic Re-Training	☐ Splinting
☐ ADL Training	☐ Patient/Family Education	☐ Work Hardening
☐ Gait Training	☐ Soft Tissue Mobilization	☐ Functional Activity
☐ Prosthetic Training	☐ Home Exercise Program	☐ Modalities as Indicated

☐ Will update and/or modify goals/Plan of Care as needed

Patient understand diagnosis/prognosis and consents to treatment plan and goals: ☐ Yes ☐ No

	Frequency:	**Duration:**

I certify that I have examined the patient and occupational therapy is necessary. The patient is under my care and the plan will be reviewed every 30 days or more often if the patient's condition requires.

Date	Occupational Therapist's Signature	Date	Physician's Signature