[Company Name]
Inpatient Occupational Therapy Evaluation

Patient Name:	**Physician Name:**
Diagnosis:	**Onset Date:**
Precautions:	
Past Medical History:	
Patient/Family Goals:	
Previous Level of Function:	
Social Environment (Living Arrangements, Equipment, Etc.)	

Physical Assessment

Speech: ☐ WNL ☐ Impaired **Vision:** ☐ WNL ☐ Impaired **Hearing:** ☐ WNL ☐ Impaired
UE ROM:
UE Strength:
Subluxation: ☐ Yes ☐ No **Fine Motor Coordination:** ☐ WNL ☐ Impaired **Gross Motor Coordination:** ☐ WNL ☐ Impaired
Hand Dominance: ☐ Right ☐ Left
Transfers: ☐ Independent ☐ SBA ☐ Minimal Assist ☐ Moderate Assist ☐ Maximum Assist ☐ Total Assist
Bed Mobility: ☐ Independent ☐ SBA ☐ Minimal Assist ☐ Moderate Assist ☐ Maximum Assist ☐ Total Assist
Balance: Sitting Static ☐ Good +/- ☐ Fair +/- ☐ Poor +/- **Dynamic** ☐ Good +/- ☐ Fair +/- ☐ Poor +/- **Standing Static** ☐ Good +/- ☐ Fair +/- ☐ Poor +/- **Dynamic** ☐ Good +/- ☐ Fair +/- ☐ Poor +/-
ADL's:
Sensation: ☐ Intact ☐ Impaired ☐ Absent
Skin:
Pain Level/Precipitating Factors/Aggravating Factors:
Barriers to Learning:
Rehab Potential: ☐ Good ☐ Fair ☐ Poor
Assessment:
Goals:
Treatment Plan:

THERAPIST'S SIGNATURE:	**PHYSICIAN'S SIGNATURE:**
DATE:	**DATE:**