# OCCUPATIONAL THERAPY EVALUATION

DATE OF SERVICE ____/____/____

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

TIME IN ________ OUT ________

**HOMEBOUND REASON:** ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) ________

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ____/____/____
(if Initial Evaluation, complete Occupational Therapy Care Plan)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If No, orders are ________

## PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM ________

________ ONSET ____/____/____

MEDICAL PRECAUTIONS ________

PRIOR LEVEL OF FUNCTION/WORK HISTORY ________

________

LIVING SITUATION/SUPPORT SYSTEM ________

ENVIRONMENTAL BARRIERS ________

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED ________

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S- Severely Impaired, U- Untested/Unable to Test

## SENSORY/ PERCEPTUAL MOTOR SKILLS

| Area | Sharp/Dull | | Light/Firm Touch | | Proprioception | |
|---|---|---|---|---|---|---|
| | Right | Left | Right | Left | Right | Left |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

VISUAL TRACKING:
R/L DISCRIMINATION:
MOTOR PLANNING PRAXIS:
Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No
If Yes, recommendations:
COMMENTS:

## COGNITIVE STATUS/COMPREHENSION

| Area | I | MIN | MOD | S | U |
|---|---|---|---|---|---|
| MEMORY Short term | | | | | |
| Long term | | | | | |
| SAFETY AWARENESS | | | | | |
| JUDGMENT | | | | | |
| Visual Comprehension | | | | | |
| Auditory Comprehension | | | | | |

ABILITY TO EXPRESS NEEDS
ATTENTION SPAN
ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy

## PSYCHOSOCIAL WELL-BEING

INITIATION OF ACTIVITY
COPING SKILLS ☐ Evaluate Further
SELF-CONTROL

## MOTOR COMPONENTS (Enter Appropriate Response)

| Area | I | MIN | MOD | S | U | | I | MIN | MOD | S | U |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FINE MOTOR COORDINATION (R) | | | | | | GROSS MOTOR COORDINATION (R) | | | | | |
| FINE MOTOR COORDINATION (L) | | | | | | GROSS MOTOR COORDINATION (L) | | | | | |

PRIOR TO INJURY: ☐ Right Handed ☐ Left Handed ORTHOSIS: ☐ Used ☐ Needed (Specify):

## MUSCLE STRENGTH/ FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)

| PROBLEM AREA | STRENGTH | | ROM | | ROM TYPE | | | TONICITY | | OTHER DESCRIPTIONS |
|---|---|---|---|---|---|---|---|---|---|---|
| | Right | Left | Right | Left | P | AA | A | Hyper | Hypo | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

COMMENTS: ________

________

| PATIENT/CLIENT NAME: Last, First, Middle Initial | ID #: |
|---|---|
| | |

# OCCUPATIONAL THERAPY EVALUATION (Cont.)

## FUNCTIONAL MOBILITY/BALANCE EVALUATION

| TASK | SCORE | COMMENTS | TASK | SCORE | COMMENTS |
|---|---|---|---|---|---|
| BED MOBILITY | | | DYNAMIC SITTING BALANCE | | |
| BED/WHEELCHAIR TRANSFER | | | STATIC SITTING BALANCE | | |
| TOILET TRANSFER | | | STATIC STANDING BALANCE | | |
| TUB/SHOWER TRANSFER | | | DYNAMIC STANDING BALANCE | | |

## SELF CARE SKILLS

| TASK | SCORE | COMMENTS | TASK | SCORE | COMMENTS |
|---|---|---|---|---|---|
| FEEDING | | | TOILETING | | |
| SWALLOWING | | | BATHING | | |
| FOOD TO MOUTH | | | UE DRESSING | | |
| ORAL HYGIENE | | | LE DRESSING | | |
| GROOMING | | | MANIPULATION OF FASTENERS | | |

## INSTRUMENTAL ADL'S

| TASK | SCORE | COMMENTS | TASK | SCORE | COMMENTS |
|---|---|---|---|---|---|
| LIGHT HOUSEKEEPING | | | USE OF TELEPHONE | | |
| LIGHT MEAL PREPARATION | | | MONEY MANAGEMENT | | |
| CLOTHING CARE | | | MEDICATION MANAGEMENT | | |

PATIENT GOALS:

**PATIENT SIGNATURE VERIFYING VISIT:**

Complete TIME OUT (on front) prior to signing here --> THERAPIST SIGNATURE/TITLE ____________________ DATE ___/___/___

# OBJECTIVE DATA TESTS AND SCALES

## MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

| GRADE | DESCRIPTION |
|---|---|
| 5 | Normal functional strength - against gravity - full resistance |
| 4 | Good strength - against gravity with some resistance. |
| 3 | Fair strength - against gravity - no resistance - safety compromise. |
| 2 | Poor strength - unable to move against gravity. |
| 1 | Trace strength - slight muscle contraction - no motion. |
| 0 | muscle contraction. |

## FUNCTIONAL RANGE OF MOTION (ROM) SCALE

| GRADE | DESCRIPTION |
|---|---|
| 5 | 100% active functional motion. |
| 4 | 75% active functional motion. |
| 3 | 50% active functional motion. |
| 2 | 25% active functional motion. |
| 1 | Less than 25%. |

## FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE

| GRADE | DESCRIPTION |
|---|---|
| 5 | Physically able and does task independently. |
| 4 | Verbal cue (VC) only needed. |
| 3 | Stand-by assist (SBA) - 100% patient/client effort. |
| 2 | Minimum assist (Min A) - 75% patient/client effort. |
| 1 | Maximum assist (Max A) - 25% - 50% patient/client effort. |
| 0 | Totally dependent - total |

## AVERAGE RANGES OF JOINT MOTION (ROM)

| AREA | ACTION/ MOVEMENT | | | |
|---|---|---|---|---|
| Shoulder | Flex | 158° | Extend | 55° |
| | Abd. | 170° | Add. | 50° |
| | Int. rot. | 70° | Ext. rot. | 90° |
| Elbow | Flex | 145° | Ext. | 0° |
| Forearm | Sup. | 85° | Pron. | 70° |
| Wrist | Flex | 73° | Ext. | 70° |
| Fingers | Flex all | 90° | Ext. | 0° |
| Thumb | Abduction | 50% | | |
| Cervical Spine | Flex | 35° | Ext. | 35° |
| | Rotation | 45° | | |

## BALANCE SCALE (sitting-standing)

| GRADE | DESCRIPTION |
|---|---|
| 5 | Independent |
| 4 | Verbal cue (VC) only needed. |
| 3 | Stand-by assist (SBA) - 100% patient/client effort. |
| 2 | Minimum assist (Min A) - 75% patient/client effort. |
| 1 | Maximum assist (Max A) - 25% patient/client effort. |
| 0 | Totally dependent for support. |