Healing Hands Home Health Care
Occupational Therapy Evaluation

Name:_____ _____ Date: _____

Time in:_____ Time out:_____

Address:_____

Phone number:_____ Physician:_____

Diagnosis:_____

Certification Period: _____ to _____

Subjective History: _____

_____

Prior level of functioning: _____

_____

Functional Status	INDEP	V/C	SBA	CGA	MIN	MOD	MAX	ASSIST DEVICE	Comments
Bed Mobility:									
Sit to Stand Transition									
Transfer: **Bed** **Toilet** **Tub/ Shower** **Chair** **W/C**									**Stand Pivot** **Sliding** **Level** **Hoyer Lift** **Instruction** ☐**Pt** ☐**Caregiver**
Feeding									
Dressing: **Upper Body** **Lower Body**									
Bathing: **Upper Body** **Lower Body**									
Grooming:									
Toilet Mgmt:									
Meal Prep:									
Laundry"									
Home Mgmt:									

Equipment: ☐Wheelchair ☐Walker ☐Cane ☐Lift Chair ☐Hoyer Lift
☐Grab Bar ☐ Bath Bench ☐Hospital Bed ☐Bedside Commode
☐ Toilet riser ☐Hand-Held shower ☐Other _____

Pain (location, severity):
Sensation/ Proprioception:
Cognition:
Visual- Perceptual:
Posture/ Balance:
Psychosocial:
Endurance:

Dominance: ☐ L ☐R

	Right Upper Extremity	Left Upper Extremity
Range of Motion		
Strength		
Coordination		
Sensation		
Tone		

Other: _____

Circle if observed: Edema Subluxation Pain Spasticity Neglect

Grip Strength: Right_____ Left _____

Assessment:	Patient Goals:
	Treatment Objectives:
Rehab Potential: ☐Excellent☐Good☐Fair☐Guarded☐Poor	

Comments/ Other	Treatment Modalities ☐D1 Evaluation ☐D7 Neuro Developmental Treatment
	☐D2 Adls/ self-care ☐D8 Sensory Treatment
	☐D3 Muscle Re-education ☐D9 Orthotics/ Splinting
	☐D5 Perceptual Motor Training ☐D10 Adaptive Equipment
	☐D6 Fine Motor Coordination ☐D11 Others

Education/ Misc. Recommendations: _____

_____

Home Bound Status:_____

Frequency	Duration	Pt/ Family Informed Services ☐Yes ☐No
		Communication with:
		Re:

☐Evaluation Only Client Signature:_____

Therapist Name: _____ Physician Name: _____

Therapist Signature: _____ Physician Signature: _____

Date: _____