Pediatric OT Evaluation
Clinical Observation

Name:_____
Diagnosis: _____
Caregiver: _____
Phone #: _____
E-mail: _____

DOB: _____
DOE: _____
Age: _____

Significant/Medical History:

_____
_____
_____
_____
_____

Medications:

_____
_____
_____

Allergies:

_____
_____
_____

Adaptive Equipment/Current Adaptations:

_____
_____
_____
_____

Other Therapies:

_____
_____
_____

Pediatric OT Evaluation
Clinical Observation

Observations:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Attending Skills

_ adequate
_ inconsistent
_ distractible
_ alert
_ lethargic
_ non-responsive

Response Rate

_ appropriate
_ impulsive
_ mild delays
_ moderate delays
_ severe delays

Social Interactions

_ WNL
_ shy
_ withdrawn
_ friendly
_ talkative

Behavior

_ present
_ non-existent
_ appropriate
_ aggressive
_ easily frustrated

Level of Activity

_ WNL
_ active
_ passive

Cooperation

_ adequate
_ with some prompts
_ with numerous prompts
_ resists

Awareness of Environmental Events

_ usually
_ moderately
_ occasionally
_ non-existent

Awareness of Others

_ adequate
_ fair
_ poor
_ non-existent

Reliability of Scores

_ good
_ questionable
_ poor

Prognosis of Therapeutic Intervention

_ favorable
_ guarded
_ unfavorable

Assessments Performed:

_____
_____
_____
_____

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FINE MOTOR

Hand Dominance

_ left
_ right
_ ambidextrous

Translation

_ functional
_ independent
_ with assistance
_ unable

In-hand Manipulation

_ functional
_ independent
_ with assistance
_ unable

Shift

_ functional
_ independent
_ with assistance
_ unable

Opposition

_ functional
_ independent
_ with assistance
_ unable

Grasp

_ palmar supinate
_ radial cross palmar grasp
_ digital pronate
_ static tripod
_ dynamic tripod

Web Space

_ open
_ closed
_ tool rested on web space

Bilateral Coordination

_ functional
_ independent
_ with assistance
_ unable

Simple/Complex Rotation

_ functional
_ independent
_ with assistance
_ unable

GROSS MOTOR

Muscle Tone

_ hypotonic
_ hypertonic
_ normal

Muscle Strength

_ good
_ fair
_ poor

Mobility

_ functional
_ independent
_ with assistance
_ unable

Reflexes

_ integrated
_ absent

Bilateral Upper Extremity

_ good
_ fair
_ poor

Standing/Hopping on One Foot

_ age appropriate
_ delayed

Jumping

_ age appropriate
_ delayed

Stairs

_ age appropriate
_ delayed

Skipping

_ age appropriate
_ delayed

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Sitting Balance:	Static	Dynamic	Activity Tolerance
	_ normal _ good _ fair _ poor _ trace	_ normal _ good _ fair _ poor _ trace	_____ mins

Standing Balance:	Static	Dynamic	Activity Tolerance
	_ normal _ good _ fair _ poor _ trace	_ normal _ good _ fair _ poor _ trace	_____ mins

SENSORY INTEGRATION

Sensory Modulation

_ sensory seeker
_ sensory avoider
_ sensory dormant
_ sensory defensive/hyper-responsive

Sensory Processing

_ gravitational
_ postural
_ vestibular
_ auditory
_ oral
_ tactile
_ visual
_ olfactory
_ gustatory

VISUAL/MOTOR PERCEPTUAL

Visual Impairments

_ none
_ wears glasses
_ wears contacts
_ other

Follows Moving Target

_ horizontally
_ vertically
_ diagonally
_ peripherally

Eyes Converge

_ yes
_ no

Eyes Diverge

_ yes
_ no

Visually Locates

_ from chalkboard to paper
_ from book to paper

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SOCIAL SKILLS

Plays with Peers

_ functional
_ independent
_ with assistance
_ unable

Plays with Toys

_ functional
_ independent
_ with assistance
_ unable

Completes Activity

_ functional
_ independent
_ with assistance
_ unable

Plays on Playground/Gym

_ functional
_ independent
_ with assistance
_ unable

Gathers/Organizes Materials Needed for Activity

_ functional
_ independent
_ with assistance
_ unable

Problem Solves a Functional Activity

_ functional
_ independent
_ with assistance
_ unable

Observes Safety Precautions

_ functional
_ independent
_ with assistance
_ unable

Participates in Individual or Group Leisure Activities

_ functional
_ independent
_ with assistance
_ unable

ACTIVITIES OF DAILY LIVING

Washes Dries Hands

_ functional
_ independent
_ with assistance
_ unable

Finger Feeds

_ functional
_ independent
_ with assistance
_ unable

Drinks from Straw

_ functional
_ independent
_ with assistance
_ unable

Drinks from Cup

_ functional
_ independent
_ with assistance
_ unable

Self Feeds Using Utensils

_ functional
_ independent
_ with assistance
_ unable

Sets-up Meal Containers/Utensils

_ functional
_ independent
_ with assistance
_ unable

Manipulates Clothing Fasteners

_ functional
_ independent
_ with assistance
_ unable

Transfers to and from Toilet

_ functional
_ independent
_ with assistance
_ unable

Pediatric OT Evaluation
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Parental Concerns:

_____
_____
_____
_____
_____
_____
_____
_____

Diagnosis/Impressions:

_____
_____
_____
_____
_____
_____
_____
_____

Recommendations:

Occupational Therapy **is** recommended: _____

Occupational Therapy **is not** recommended: _____

Frequency: _____ Duration: _____

_____ _____
Evaluator Date