2497 State Road
Cuyahoga Falls, Oh 44223
330-929-5512

OCCUPATIONAL THERAPY HOME EVALUATION

Patient Name _____DOB _____ ☐ Verified ☐ Male ☐ Female

Address _____ ☐ Verified

Phone _____ Diagnosis _____

Physician _____ Physician Phone_____

Certification Period _____ to _____ Date of Referral _____

Diagnosis _____

Patient Goals _____

Past Medical/Surgical History _____

Dr. Orders _____ Homebound Status _____

Prior Functional Status_____

Current Environment:

Living ☐ Alone ☐ Spouse ☐ Family ☐ Other _____
☐ Ranch ☐ Apartment ☐ Two Story ☐ Other _____
Stairs ☐ Yes ☐ No Comments _____
Doorways W/C Accessible ☐ Yes ☐ No
Safety Factors _____

Patient / Caregiver response to Therapy:

☐ Good ☐ Fair ☐ Poor Comments:_____

Physical Status: *(WNL=Within Normal Limits; ABN=Abnormal; NE=Not Evaluated)*

Hand Dominance ☐ Right ☐ Left Coordination: Gross _____ Fine _____
Endurance _____

		WNL	ABN	NE	COMMENTS
BALANCE EQUILIBRIUM	SITTING/STANDING				
RIGHT U/E FUNCTION	PROM				
	AROM				
	STRENGTH				
	MUSCLE TONE				
	SENSATION				
LEFT U/E FUNCTION	PROM				
	AROM				
	STRENGTH				
	MUSCLE TONE				
	SENSATION				
ORIENTATION					
ATTENTION SPAN					
MEMORY					
PROBLEM SOLVING					
VISUAL / SPACIAL RELATIONS					
BODY IMAGE					
LANGUAGE SKILLS					
ABILITY TO FOLLOW DIRECTIONS					
MOTOR PLANNING					

Patient Name _____

Equipment:

☐ Walker ☐ Cane ☐ W/C ☐ BSC ☐ Tub Bench ☐ Leg Brace
☐ Raised Toilet Seat ☐ Hospital Bed ☐ Trapeze ☐ Sling ☐ Splint ☐ Reachers
☐ Hand Held Shower ☐ Safety Bars ☐ Sock Aide ☐ Dressing Stick
☐ Long Handled Sponge ☐ Long Shoe Horn ☐ Other _____

Activities of Daily Living (ADL's)		INDEP	ASSIST	DEPEND	N/A	COMMENTS
FEEDING	Right / Left Hand					
GROOMING	Comb Hair					
	Teeth / Denture Care					
	Shave / Make up					
BATHING	Tub / Shower / Sponge					
	UE Bathing					
	LE Bathing					
DRESSING	UE Dressing					
	LE Dressing					
	Shoe / Sock Donning / Doffing					
	Fastening / Unfastening Buttons, etc.					
HOMEMAKING	Cooking					
	Laundry					
	Cleaning					
	Bed Making					
	Home Maintenance					
	Miscellaneous					
AVOCATIONAL / LEISURE PURSUITS						
FUNCTIONAL MOBILITY / TRANSFERS	Bed Mobility					
	Tub / Shower / Transfers					
	Walker / Cane / W/C Mobility					
	Toilet					

Add'tl Comments:_____

_____

OT Problems:_____

_____

OT Goals:_____

_____

Tx Method: _____

_____

_____

Freq / Duration:_____ **Rehab Potential for Goals Established**: ☐ Good ☐ Fair ☐ Poor

Discharge Plan:_____

_____

_____

Patient / CG Signature _____ Date _____

OT Signature _____ License # _____ Date _____

Time In _____ Time Out _____