T.O.N.E
Home Health Services, Inc.
Treating Ongoing Needs Effectively

OCCUPATIONAL THERAPY EVALUATION

OBJECTIVE DATA TESTS AND SCALES PRINTED ON REVERSE.

DATE OF SERVICE _____/_____/_____

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)________________________________

SOC DATE_____/_____/_____
(If Initial Evaluation, complete Occupational Therapy Care Plan)

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM ________________________________
________________________________ ONSET_____/_____/_____
MEDICAL PRECAUTIONS ________________________________
PRIOR LEVEL OF FUNCTION/WORK HISTORY ________________________________
____
DESCRIBE PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED ________________________________
________________________________ FALL RISK: ____________
LIVING SITUATION/SUPPORT SYSTEM ________________________________
ENVIRONMENTAL BARRIERS ________________________________
PAIN (describe)________________________________ Impact on therapy care plan? ☐ Yes ☐ No

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)

	I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)					
FINE MOTOR COORDINATION (L)					

	I	MIN	MOD	S	U
GROSS MOTOR COORDINATION (R)					
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 NAME – Last, First, Middle Initial	ID#

OCCUPATIONAL THERAPY EVALUATION
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