matrix
The Primary Source for Home Care

Occupational Therapy Assessment/Note

Patient/Client Name: _____ Date: _____

Diagnosis: _____ Date of Onset: _____

❒ Initial Evaluation	❒ Follow up Visit	❒ Re-evaluation
Trunk, Head, Shoulder Girdle:		
Upper Extremities:		
Hands: Dominance: ❒ Right ❒ Left		
Endurance/Speed:		
Balance: Sitting -		
Standing - Static _____ Dynamic _____		
Mobility:		
Transfer Ability:		
DME / Adaptive Equipment Used:		
ADL: Feeding -		
Dressing -		
Grooming/Hygiene -		
Bathing -		
Homemaking -		
Psychological Status:		
Instruction:		
Patient Progress Toward Goals:		
Rehabilitation Program:		
Safety Risks Identifies:		

Independent Living/Daily ADLs		Perceptual Motor Training		Orthotics/Splinting	
Muscle Re-education		Fine Motor Coordination		Adaptive Equipment	
Reserved		Neurodevelopmental Treatment		Other	
Other		Sensory Treatment			

Time In:_____ Time Out: _____

Patient/Designee: I certify that the Matrix Home Care Employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.

Patient/Client Signature: _____

OT Name (Print):_____ OT Signature:_____