

Occupational Therapy Admission Assessment

Patient Name: _____ Chart #: _____

Diagnosis: _____ Date: _____

Referring Doctor: _____ Treatment Requested: _____

Data Base

Patient's Concerns / Goals: _____

History (onset, course of disease, related surgery, previous therapy):

Other Medical Conditions: _____

Arthritis Medications: Current: _____

Previous: _____

Herbs / Supplements: _____

Morning Stiffness: _____

Fatigue / Sleep Patterns: _____

Patient Profile (social support, living situation, employment):

Self-management strategies: _____

PEP Classes (Has attended? / Would like to attend?):

Functional Summary

Mobility (walk, drive, stairs, public transport, shopping):

OT: _____

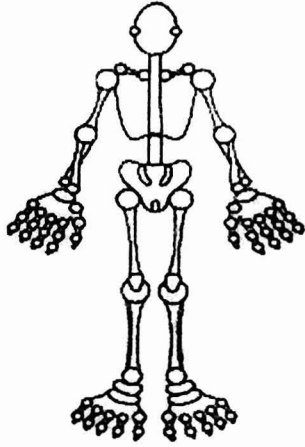
Self-care (dressing, bathing, toileting, feeding, transfers):

Productivity (housework, home maintenance, paid or unpaid work, child care):

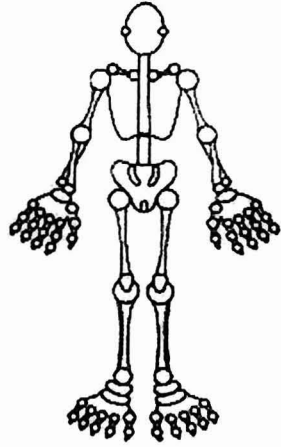
Leisure (reading, hobbies, sports, travel, visiting etc.):

Splints and Adaptive Equipment (present and past):

Musculoskeletal Review and Impact on Function



Active Joints



Damaged Joints

T.M.J.:

Cervical spine:

Back:

Shoulder:

Elbow:

Wrist:

Name: _____

Chart #: _____

Hands:

Hips:

Knees:

Ankles:

Feet:

OT: _____

