OCCUPATIONAL THERAPY

Daily Treatment & Goal Progress Monitoring

DATA COLLECTION & DOCUMENTATION FORMS

OCCUPATIONAL THERAPY
Daily Treatment & Goal Progress Monitoring

STUDENT NAME: _____ SCHOOL YEAR: _____ MONTH: _____

DOB: _____ CASE ID #: _____ GENDER: MALE ☐ FEMALE ☐ SERVICE LEVEL: _____

DIAGNOSIS/ALERTS: _____ TREATMENT SETTING: _____

PROVIDER: _____ PROVIDER LICENSE#: _____

REFERRING PHYSICIAN: _____ ICD CODE: _____

GOAL(S)/OBJECTIVE(S):

DATE OF SERVICE	START/END TIME	TREATMENT CODE(S)

AREAS ADDRESSED:

- ☐ Adaptive Equipment/Assistive Tech.
- ☐ ADLs/Life Skills
- ☐ Balance Activities
- ☐ Bilateral Coordination
- ☐ Coordination/Motor Planning
- ☐ Fine Motor Coordination
- ☐ Functional Mobility Training
- ☐ Handwriting Skills
- ☐ Muscle Tone/Control
- ☐ Sensory Activities/Self-Regulation
- ☐ Strengthening/Core Strength
- ☐ Therapeutic Exercise
- ☐ Upper Extremity/Hand ROM
- ☐ Visual Motor Skills
- ☐ Visual Perceptual Skills
- ☐ Other:

GOAL #	TRIALS					TOTAL	%

PROGRESS NOTE:

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GOAL #	TRIALS					TOTAL	%

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PROVIDER SIGNATURE/CREDENTIALS/DATE

KEY: + MET CRITERIA – DID NOT MEET CRITERIA

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