Pediatric Occupational Therapy Treatment Plan

Date: _____ dd / mm / yyyy **Client's name:** _____

Client's age: _____

Date of client's previous occupational therapy treatment plan (if applicable): dd / mm / yyyy

Client's diagnosis (if applicable): _____

Client's precautions, restrictions, or contraindications (if applicable):

Is client currently receiving additional therapies or services?

◯ Yes ◯ No

If yes, please provide more details:

Is client currently in school?

◯ Yes ◯ No

If yes, please provide more details:

If client is currently in school, are they receiving any therapies or supports at school?

◯ Yes ◯ No

Please provide more details:

Client's strengths:

Client's areas of need:

Feedback, questions, comments, or concerns from the client's caregiver (if applicable):

Frequency of client's therapy:

Areas addressed with client:

- [ ] Activities of Daily Living (ADLs)
- [ ] Health Management
- [ ] Leisure
- [ ] Rest and Sleep
- [ ] Social Participation
- [ ] Other
- [ ] Education
- [ ] Instrumental Activities of Daily Living (IADLs)
- [ ] Play
- [ ] School
- [ ] Work

Please provide more details on selected areas addressed with client:

GOALS

Goal 1:

Goal 1 Status/Comments:

Goal 2:

Goal 2 Status/Comments:

Goal 3:

Goal 3 Status/Comments:

Goal 4:

Goal 4 Status/Comments:

Goal 5:

Goal 5 Status/Comments:

Summary of services provided to client:

Client's current performance:

Plan and recommendations:

Estimated length of treatment: _____