Occupational Therapy
Client Self Evaluation

Name______________________ Date____________

Please check the box that best matches how you feel about each area:

Performance Areas	Concern	Satisfactory	Strength
Personal Care (showering, clean clothes, brushing teeth and hair)			
Communicating with others (following ideas, sociable, able to carry on conversation)			
Sexual health (safety, body image, education, relations, emotional self)			
Thinking Skills (paying attention, processing situations, judgment, problem solving)			
Organization (sequencing of thoughts or tasks throughout the day, making appointments)			
Your home (stable home, participating in household responsibilities, food and clothing is available)			
Changing Scenery (able to handle home to going out, moving from quiet to loud rooms)			
Daily Structure (typical routine, schedule, work, school, hobbies)			
Interpersonal Skills (eye contact, posture, socially appropriate responses, anger management, appropriate emotions)			
Motivation (desire to complete responsibilities and daily activities)			
Interests (able to identify enjoyable activities, hobbies)			
Living environment (stability of home, note: chaotic vs. organized, presence of resources)			
Community Management (accessing transportation, shopping, finances)			
Social Support (family, friends, mentors, teachers)			
Stress Management (coping strategies, exercise, quiet leisure, self care routine			

Additional comments: