



## REVIEWING YOUR ASSESSMENT

Please check “yes” or “no” to indicate whether your facility’s activity assessment contains the following information.

	Yes	No
<b>1. Medical Information</b>	___	___
<b>2. Background Information/Family History</b>	___	___
<b>3. Social/Cultural Information</b>	___	___
<b>4. Occupational Background</b>	___	___
<b>5. Current Abilities</b>		
Cognitive		
Short Term Memory	___	___
Long Term Memory	___	___
Level of Orientation	___	___
Decision Making Abilities	___	___
Attention Span	___	___
Communication abilities	___	___
Judgment	___	___
Physical		
Mobility	___	___
Dexterity/Praxic abilities	___	___
Hearing/Vision	___	___
Adaptive Devices	___	___
Time Awake	___	___
Precautions	___	___
Pain	___	___
Psychosocial Status		
Emotional Well-being	___	___
Adjustment to life situation	___	___
Spiritual needs	___	___
Social Abilities	___	___
Mood/Behaviors during Activities	___	___
<b>6. Participation Level in Activities</b>		
Average number of Activities attended per week/month	___	___
Average Time Involved in Activities	___	___
Independent Leisure pursuits	___	___
Active/Passive participant	___	___
Response to Activities / Intervention	___	___
One to One needs	___	___
<b>7. Assessment and Plan</b>		
Activities Plan	___	___
Progress toward CP goal	___	___
Benefits/outcome of plan	___	___
<b>8. Other Special Considerations</b>	___	___