Occupational Therapy
Daily Notes

Student's Name: ____________________ **Date of Birth:** ____________________

School: ______________________________ **Therapist:** ______________________

Date of Service: ______________

_____Direct Treatment _____Consultation

_____Individual _____Group

Treatment Provided:

	Fine Motor		Handwriting		Professional Training
	Visual Motor		Visual Perceptual		Functional Skills
	Gross Motor		Motor Planning		Adaptive Equipment
	Range of Motion		Strengthening		Therapeutic Handling
	Activities of Daily Living		Positioning		Feeding

Outcome:

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Signature of OT/COTA, Date Signature of Supervising OT