



Occupational Therapy Goal Setting Form

Client's Name: _____ Date: _____

Person Completing Form: _____ Relationship: _____

<p>Please indicate below 5 or 6 goals you would like to see your child achieve in the next _____. Think about what you would like your child to be able to do/ or have accomplished at the end of that time period. Below are various areas of function that OT services may impact upon. Ratings for Rank Order of Priority: 1=Most Important to You; 5 =Least Important to You</p>	<p>Rank Order Of Priority (rate 1- 5)</p>
<p>Body and Sensory Functions: <i>This area includes changes in sensory functioning such as decreasing tactile defensiveness, improving force control; and body functions such as sitting posture, coordination or balance.</i></p>	
<p>Activities: <i>This area includes those tasks or activities engaged in/performed by the child and can include specific skills like writing/fine-motor skills, dressing, or throwing/ catching a ball.</i></p>	
<p>Participation: <i>This area includes the child's ability to engage in/be involved in life situations such as going to birthday parties, going out to restaurants, participating in team sports and/or play dates.</i></p>	
<p>Environment: <i>This area includes aspects of the context/environment that the parents must adapt or control in order for the child to function (i.e.: needing to structure play dates, having to vacuum only when the child is out of the house, planning transitions, cutting nails when the child is asleep, or needing to bring food to a restaurant).</i></p>	
<p>Family: <i>This area includes aspects of the family's daily living activities that are impacted by the child's sensory processing dysfunction such as the ability to sit down at a family meal all together, go on family outings, and/or feelings that the family's life revolves around the child.</i></p>	