

Central State Hospital

620 Broad St.
Milledgeville, GA 31062

ACTIVITY THERAPY ASSESSMENT

NAME: _____

ADMISSION DATE: _____

ID#: _____

SOURCE(S) OF INFORMATION:

Interview with the following: (Check only those which apply)

Individual Staff member(s): _____

Family member(s) or friends: _____

Review of records (specify): _____

Other: _____

REASON FOR ASSESSMENT: Admission/Initial Annual Other: _____

PERTINENT DIAGNOSIS/HISTORY: _____

REASON(S) FOR ADMISSION: _____

SUBSTANCE ABUSE ISSUES: None identified as current Current issues: _____

RISK CONDITIONS AND/OR PRECAUTIONS: _____

CULTURAL AND/OR RELIGIOUS PRACTICE/ISSUES: _____

EDUCATIONAL/VOCATIONAL ISSUES: _____

ASSESSMENT TOOLS UTILIZED: _____

CLINICAL OBSERVATIONS:

Affect: Appropriate Labile Flat Hostile Euphoric Manic Other: _____

Mood: Appropriate Irritable Anxious Hostile Depressed Other: _____

Thought Process: Oriented x 4 Disoriented Poor Memory Poor concentration Insightful

Disorganized Other: _____

Thought Content: Hallucinations Delusions Suicidal Ideation Homicidal Ideation Self Injurious Behaviors Other: _____

Cooperation: Cooperative Refused to participate in evaluation Limited: _____

Eye contact: Appropriate Limited Fixed Other: _____

Verbal interaction: Functional Inappropriate language or tone Pressured speech Nonverbal

Appears to have receptive and/or expressive language difficulty Other: _____

LEISURE PROFILE: _____

PHYSICAL FUNCTIONING: No limitations Specific abilities, strengths, and/or limitations: _____

COGNITIVE FUNCTIONING: No limitations Specific abilities, strengths, and/or limitations: _____

SOCIAL FUNCTIONING: No limitations Specific abilities, strengths, and/or limitations: _____

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LIFE SKILL FUNCTIONING (Including transportation issues): No limitations

Specific abilities, strengths, and/or limitations: _____

ANALYSIS OF FINDINGS:

Individual's priorities and life goals: _____

Present functional status: _____

Environments, modalities, preferences, and/or strategies that support learning and/or performance or may hinder performance: _____

Implications for Discharge Planning: _____

Recommendations for additional assessments or evaluation: None List: _____

Recommended Goal(s):

Recommended Objective(s):

Recommended Intervention(s):

Signature and date