

Occupational Therapy Progress Note

Date

YYYY-MM-DD

Therapist

Therapist Name

Client Name

DOB

YYYY-MM-DD

Session #

Subjective

Client's description of symptoms, concerns, progress, or reports.

Objective

Observations, measurable data, interventions provided, activities completed.

Assessment

Therapist's professional assessment of progress, barriers, and response to interventions.

Plan

Future interventions, goals, recommended actions.

Therapist Signature

Date

YYYY-MM-DD