Name: _____

aequor
HEALTHCARE SERVICES

Skills Checklist

OCCUPATIONAL THERAPIST & ASSISTANT SELF-ASSESSMENT SKILLS CHECKLIST

By accurately filling out this checklist, you will help us match your skills and interests with available assignments. Please place an "X" in the column that best describes your experience level with each skill.

Level of Proficiency:
1. Can function independently
2. Experienced but may need review
3. Limited experience
4. No experience

Orthopedics	1	2	3	4
Arthritis Program	❑	❑	❑	❑
General Ortho	❑	❑	❑	❑
Hand Injury	❑	❑	❑	❑
Hip Fractures	❑	❑	❑	❑
Mobilization Techniques	❑	❑	❑	❑
Total Hip/Total Knee	❑	❑	❑	❑
Total Joint Replacement	❑	❑	❑	❑

Neuro	1	2	3	4
Cerebral Vascular Accident	❑	❑	❑	❑
Cognitive Retraining	❑	❑	❑	❑
Head Trauma	❑	❑	❑	❑
Spinal Cord Injury	❑	❑	❑	❑
Parkinson's Disease	❑	❑	❑	❑

Pediatrics	1	2	3	4
Cerebral Palsy	❑	❑	❑	❑
Developmental Screening	❑	❑	❑	❑
Early Intervention	❑	❑	❑	❑
Learning Disabilities	❑	❑	❑	❑
Neurodevelopmental Testing	❑	❑	❑	❑
Spina Bifida	❑	❑	❑	❑
Visual Perception Testing	❑	❑	❑	❑
Autism	❑	❑	❑	❑
Down's Syndrome	❑	❑	❑	❑
Mental Retardation	❑	❑	❑	❑

Modalities	1	2	3	4
Biofeedback	❑	❑	❑	❑
Edema Massage	❑	❑	❑	❑
Feeding Techniques	❑	❑	❑	❑
Fluidotherapy	❑	❑	❑	❑
Oral Motor Facilitation	❑	❑	❑	❑
Muscle Stimulation	❑	❑	❑	❑
Paraffin Bath	❑	❑	❑	❑
TENS	❑	❑	❑	❑
Theraputic Massage	❑	❑	❑	❑
Theraputic Pool	❑	❑	❑	❑

Prosthetics/Orthotics	1	2	3	4
Dynamic Splints	❑	❑	❑	❑
Functional Splinting	❑	❑	❑	❑
Orthotics	❑	❑	❑	❑
LE Prosthetics	❑	❑	❑	❑
Serial/Inhibitory Casting	❑	❑	❑	❑
Static Splints	❑	❑	❑	❑
UE Prosthetics	❑	❑	❑	❑

Other	1	2	3	4
Activities of Daily Living	❑	❑	❑	❑
Adaptive Equipment	❑	❑	❑	❑
Burn Management	❑	❑	❑	❑
Driving Evaluation	❑	❑	❑	❑
Dysphagia	❑	❑	❑	❑
Energy Conservation	❑	❑	❑	❑
Family Education	❑	❑	❑	❑
Gait Analysis	❑	❑	❑	❑
Group Dynamics	❑	❑	❑	❑
Home Accessibility	❑	❑	❑	❑
Job Task Analysis	❑	❑	❑	❑
Oncology	❑	❑	❑	❑
Pain Management	❑	❑	❑	❑
Perceptual Motor Testing	❑	❑	❑	❑
Pulmonary Rehab	❑	❑	❑	❑
Range of Motion	❑	❑	❑	❑
Sensation Testing	❑	❑	❑	❑
Wheelchair Evaluation	❑	❑	❑	❑
Wheelchair Ordering	❑	❑	❑	❑
Wheelchair Position Testing	❑	❑	❑	❑
Work Capacity Evaluation	❑	❑	❑	❑
Work Hardening	❑	❑	❑	❑
EMR Systems (Electronic Medical Records)	❑	❑	❑	❑

Years of Experience In:	# Of Yrs.
General Acute Care	_____
Rehabilitation Hospital	_____
Skilled Nursing Facility	_____
Home Health Care	_____
Orthopedics	_____
Industrial Medical Clinic	_____
Sports Medicine Clinic	_____
Outpatient Private	
Practice Clinic	_____
Children's Hospital	_____
School Systems	_____

Signature: _____ Date: _____