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OCCUPATIONAL THERAPY & WELLNESS, LLC

OCCUPATIONAL THERAPY INTAKE/MEDICAL HISTORY FORM

TODAY'S DATE: _____

NAME: _____

DOB:_____ AGE: _____ GENDER: _____

EMAIL: _____

TELEPHONE - HOME: _____ CELL: _____

PERSON COMPLETING THIS FORM IF OTHER THAN PATIENT:

_____

RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN:_____ PHONE NUMBER: _____

SPECIALIST :_____ PHONE NUMBER: _____

SPECIALIST :_____ PHONE NUMBER: _____

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

FULL NAME OF SPOUSE: _____

OTHERS LIVING IN HOME: _____

RECEIVING IN HOME ASSISTANCE ☐ YES ☐NO

IF YES, HOW OFTEN AND BY WHOM?

_____

OCCUPATION: _____

Phone: (612) 200-2640 Fax: (612) 206-8674
email: info@seethegoodot.com www.seethegoodot.com

LEISURE ACTIVITIES/HOBBIES/SPORTS:

_____

_____

HISTORY OF OCCUPATIONAL THERAPY/STATE SERVICES FOR THE BLIND

HAVE YOU WORKED WITH MINNESOTA STATE SERVICES FOR THE BLIND?

☐ **YES** ☐**NO** **WHEN?** _____

HAVE YOU HAD OCCUPATIONAL THERAPY BEFORE: ☐ **YES** ☐**NO**

WHERE? _____ **WHEN?** _____

RESULTS/AREA OF FOCUS: _____

REASON FOR DISCHARGE:_____

HISTORY OF PRESENT ILLNESS

PLEASE DESCRIBE YOUR CONCERNS:

_____

_____

_____

_____

WHEN DID THIS PROBLEM(S) BEGIN?

_____

DID THIS OCCUR GRADUALLY OR SUDDENLY?

_____

WERE YOU HOSPITALIZED FOR THIS CONDITION: ☐ **YES** ☐**NO**

IF YES, FOR HOW LONG AND WHERE?

_____

_____

_____

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WHAT DIAGNOSTICS TESTS/PROCEDURES HAVE YOU UNDERGONE FOR THIS PROBLEM (I.E. X-RAYS, MRI, EMG SURGERY?)

_____

_____

_____

PLEASE LIST FINDINGS/RESULTS:

_____

_____

_____

DO YOU HAVE ANY PAIN? ☐ YES ☐NO

IF YES, WHERE IS YOUR PAIN? _____

0-10 (0=NO PAIN – 10= WORST PAIN)

WHAT IS YOUR PAIN LEVEL AT REST: ___/10 WITH ACTIVITY: ___/10

QUALITY OF PAIN: ☐ SHARP ☐ DULL ☐ THROBBING ☐ NUMBNESS ☐ TINGLING ☐ SHOOTING ☐ BURNING ☐OTHER

_____

FREQUENCY OF PAIN: ☐ constant (76-100%) ☐frequent (51-75%) ☐occasional (26-50%) ☐rarely (25% or less)

WHAT DECREASES YOUR SYMPTOMS? _____

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PAST MEDICAL HISTORY

☐ DIABETES	☐ KIDNEY FAILURE	☐ HAND SURGERY/INJURY
☐ CHEST PAIN	☐ DIALYSIS	☐ DEMENTIA/ ALZHEIMER'S DISEASE
☐ A-FIB	☐ SEIZURES	☐ MILD COGNITIVE IMPAIRMENT
☐ EDEMA	☐ NUMBNESS/TINGLING	☐ MEMORY CHANGES
☐ COPD	☐ BACK/NECK SURGERY	☐ PARKINSON'S DISEASE
☐ CONGESTIVE HEART FAILURE	☐ SPINAL STENOSIS	☐ MULTIPLE SCLEROSIS
☐ PACEMAKER/ DEFIBRILLATOR	☐ OSTEOPOROSIS	☐ ESSENTIAL TREMOR
☐ HEART DISEASE	☐ ROTATOR CUFF INJURY	☐ MACULAR DEGENERATION
☐ CVA/TIA	☐ DEGENERATIVE JOINT DISEASE	☐ GLAUCOMA
☐ HIGH BLOOD PRESSURE	☐OSTEOARTHRITIS	☐ RETINITIS PIGMENTOSA
☐ LOW BLOOD PRESSURE	☐ RHEUMATOID ARTHRITIS	☐ DRY EYES
☐ASTHMA	☐ JOINT REPLACEMENT	☐ CATARACTS
☐ DEPRESSION	☐ FALLS	☐ OTHER: _____
☐ ANXIETY	☐ CANCER	☐ OTHER: _____

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FUNCTION:

WHAT PROBLEMS RESULTING FROM YOUR CURRENT CONDITION ARE LIM... YOUR ABILITY TO PARTICIPATE IN YOUR DAILY ACTIVITIES?

_____

_____

_____

CHECK THE FOLLOWING ACTIVITIES YOU ARE HAVING ANY DIFFICULTY WITH BECAUSE OF YOUR CONDITION:

☐ DRESSING	☐ EATING
☐ GROOMING/HYGIENE	☐ KITCHEN ACTIVITIES
☐ BATHROOM ACTIVITIES	☐ HOUSEKEEPING
☐ YARDWORK	☐ HOME MANAGEMENT
☐ MONEY/BANKING ACTIVITIES	☐ WRITING
☐ TELEPHONE USE	☐ SHOPPING
☐ TIME MANAGEMENT	☐ WORK/SCHOOL TASKS
☐ SOCIAL ACTIVITIES	☐ MOBILITY
☐ LEISURE ACTIVITIES	☐ COMPUTER
☐ READING	☐ OTHER _____
☐ OTHER _____	☐ OTHER _____

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WHAT DO YOU HOPE TO ACCOMPLISH WITH THERAPY SERVICES?

_____

_____

_____

PLEASE LIST ANY QUESTIONS YOU WOULD LIKE TO HAVE ANSWERED?

_____

_____

_____

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EMERGENCY INFORMATION SHEET:

PATIENT NAME: _____ DOB: _____

CONTACT NAME 1: _____ RELATION:_____

WORK NUMBER: (_____) _____ CELL NUMBER: (_____) _____

CONTACT NAME 2 : _____ RELATION:_____

WORK NUMBER: (_____) _____ CELL NUMBER: (_____) _____

CONDITIONS WHICH MAY REQUIRE IMMEDIATE OR EMERGENCY CARE (I.E. DIABETES, EPILEPSY, ALLERGIC REACTIONS):

1. **_____ TREATMENT: _____**
2. **_____ TREATMENT: _____**
3. **_____ TREATMENT: _____**

PLEASE ATTACH MEDICATION LIST OR INDICATE NAME OF MEDICATIONS THAT ARE TAKEN ON A REGULAR BASIS AND THE PURPOSE OF THE MEDICATION

1. **_____**
   _____
2. **_____**
   _____
3. **_____**
   _____
4. **_____**
   _____
5. **_____**
   _____
6. **_____**
   _____

PLEASE LIST ANY AND ALL ALLERGIES PATIENT HAS (FOOD, LATEX, ETC):

_____

_____

IF PATIENT BECOMES ILL OR INVOLVED IN AN ACCIDENT AND EMERGENCY CONTACT CANNOT BE REACHED, I AUTHORIZE THE FOLLOWING HOSPITAL OR ABOVE NAMED PHYSICIAN TO GIVE THE EMERGENCY MEDICAL TREATMENT REQUIRED:

HOSPITAL: _____ ADDRESS: _____

Patient and/or Responsible Party Signature:	
Date:	

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