SOL THERAPIES
1740 SE 18th Street, Suite 901, Ocala, FL 34471
sol.therapies.llc@gmail.com
☎ 352-327-8206 🖷 352-681-4077

ADULT CASE HISTORY
INTAKE FORM

Please answer the questions as fully and accurately as possible. The information that you provide on this form will help to create a better understanding of your needs and the course of evaluation and treatment. If you are unsure of a particular answer, mark with a question mark (?). If a question is not relevant, please write "N/A."All material and information is strictly confidential.

GENERAL INFORMATION

First Name	**Last Name**	**Middle Initial**	**Date of Birth**
Sex	**Phone Number**	**Email**	

Address	**City**	**State**	**Zip**
Marital Status	**Spouse/Parter's Name**	**Spouse/Parter's Phone**	
Emergency Contact	**Relationship**	**Phone Number**	

Insurance Information

Plan Name _____ □ Medicare □ Medicaid □ Uninsured

**Note: SOL Therapies does not accept insurance nor are we Medicaid or Medicare providers. This may affect your ability to work with an out-of-network provider. Please refer to your insurance or Medicaid/Medicare Representative for more information regarding private pay services.*

What Languages Do You Speak?	What is Your Primary Language?

Are You Currently Employed? ☐ YES ☐ NO	
Primary Occupation:	Years Worked:
Employer:	Job Description:
Secondary Occupation:	Years Worked:
Employer:	Job Description:

I currently live with:

Name	Relationship

How did you hear about us? □ Word of Mouth □ Google □ Facebook/Instagram □ Referral (see below)

Referred By:	Phone:
Relationship:	Email Address:

Primary Doctor:	Phone:
Office Name:	

Dentist:	Phone:
Office Name:	

Additional Specialist:	Area:
Office Name:	Phone:

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Have you ever received private occupational, speech, or physical therapy services? If yes, please describe:

☐ Yes	☐ No	
Provider(s):		

SERVICE REQUEST

□ Speech/Language	□ Feeding Therapy	□ Occupational Therapy	□ Co-Treatment (SLP and OT)
□ Deaf/Hard of Hearing	□ Assistive Technology	□ Educational Planning	□ Advocate Services

Preferred Days and Times

□ Mondays	□ Tuesdays	□ Wednesdays	□ Thursdays	□ Fridays
□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)
□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)
□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)

MEDICAL HISTORY

Please check the corresponding box if you have been diagnosed with the following (if applicable):

☐ ADD/ADHD	☐ Anxiety Disorder	☐ Asthma	☐Autism Spectrum Disorder
☐ Cleft Palate/Lip	☐ Color Blindness	☐ Ear Infections	☐ Frequent Colds
☐ Food Allergies	☐ Headaches	☐ High Fever	☐ Other Allergies
☐ Seizures	☐ Sinus Infections	☐ Sleep Apnea	☐ Muscular Dystrophy
☐ Tonsillitis	☐ Traumatic Brain Injury	☐ Concussion	☐ Cerebral Palsy
☐ Swallowing Problem	☐ Hearing Loss	☐ Reflux	☐ Motor Planning Disorder
☐ Nerve Damage	☐ Developmental Delay	☐ Diet Restrictions	☐ Sensory Processing Disorder
☐ Stroke	☐ High Blood Pressure	☐ Aphasia	☐ Migraine
☐ Heart Attack	☐ Diabetes	☐ Cancer	☐ Multiple Sclerosis

Additional diagnoses:

If any of the above have been checked, please provide the date of diagnosis and name of physician:

Describe any surgeries, major accidents or hospitalizations. Indicate if you have been under general anesthesia.

MEDICAL HISTORY (cont.)

Current Medications

Have you ever undergone genetic testing? If yes, please share the findings:

☐ Yes	☐ No	

Have you had a recent hearing test? If so, when?

☐ Yes	☐ No	

Have you had a recent vision test? If so, when?

☐ Yes	☐ No	

Exercise and Physical Activity

☐ Yes	☐ No	Type, Amount, and Frequency

Alcohol Usage

☐ Yes	☐ No	Type, Amount, and Frequency

Recreational Drug Usage

☐ Yes	☐ No	Type, Amount, and Frequency

FAMILY HISTORY

Have any close family members been diagnosed with the following		Family member(s)
Speech or Language Disorder	☐ YES ☐ NO	
Learning Disabilities (i.e. dyslexia)	☐ YES ☐ NO	
Hearing Impairment/Deafness	☐ YES ☐ NO	
Autism Spectrum Disorder	☐ YES ☐ NO	
ADD or ADHD	☐ YES ☐ NO	
Motor Planning Disorder	☐ YES ☐ NO	
Sensory Processing Disorder	☐ YES ☐ NO	

ADAPTIVE SKILLS

What social activities do you participate in? Please describe:

Do you drive? List any vehicle adaptations (special mirrors, hand brake, adaptive seating, etc.) that you need.

☐ Yes	☐ No	

Do you have any difficulty walking? Do you need any mobility aids? (cane, walker, foot braces/orthotics, wheelchair)

☐ Yes	☐ No	

ADAPTIVE SKILLS (cont.)

Do you require assistance with daily activities dressing, showering, use bathroom, making meals, etc.? If yes, please describe the level of assistance needed with each activity

☐ Yes	☐ No	

Do you have any functional eating problems (e.g. very picky eater, any problems tolerating specific food textures, difficulty swallowing, coughing on dry foods, drooling, chewing, etc.)? If yes, please describe:

☐ Yes	☐ No	

Do you have difficulty walking, running, or participating in any activities that require large muscle coordination? Do you feel that you are excessively clumsy?

☐ Yes	☐ No	

Please share any additional information/ comments regarding your living skills that you feel is important:

EDUCATIONAL HISTORY

Highest Level of Education _____

School:	Degree/Specialization:	Years Attended:

Have you ever been diagnosed with any type of learning disability? If so, please describe:

☐ Yes	☐ No	

SENSORY INFORMATION

Do you have an adverse (negative) reaction to any of the following?

Loud Noises	☐ Yes	☐ No
Bright Lights	☐ Yes	☐ No
Certain Food Textures	☐ Yes	☐ No
Having Teeth Brushed	☐ Yes	☐ No
Having Face Touched	☐ Yes	☐ No
Having Hair Brushed	☐ Yes	☐ No
Tags in Clothes	☐ Yes	☐ No
Wearing Socks/Shoes	☐ Yes	☐ No
Wearing Tight Clothing	☐ Yes	☐ No
Car Sickness	☐ Yes	☐ No
Using the Bathroom (home)	☐ Yes	☐ No
Being Hugged	☐ Yes	☐ No

Animals (dogs, cats)	☐ Yes	☐ No
Motion Sickness	☐ Yes	☐ No
Dirt, Paint, etc., on hands	☐ Yes	☐ No
Large Crowds	☐ Yes	☐ No
Doctor's Office	☐ Yes	☐ No
Dentist's Office	☐ Yes	☐ No
New Routines	☐ Yes	☐ No
Separating from a familiar person	☐ Yes	☐ No
Music playing on stereo, phone, etc.	☐ Yes	☐ No
Someone Singing	☐ Yes	☐ No
Using Public Restrooms	☐ Yes	☐ No

SENSORY INFORMATION (continued)

Do you have a normal response to pain? (e.g. high pain tolerance, easily injured) If no, please describe.

☐ Yes	☐ No	

Would you describe yourself as hyperactive (always moving, can't sit still)? Please describe.

☐ Yes	☐ No	

Do you have difficulty paying attention/keeping focus for more than 30 minutes? Please describe.

☐ Yes	☐ No	

Do you engage in any repetitive behaviors? (e.g. rocking in chair, picking nails, fixing hair, opening and closing doors, triple checking for errors, etc.) Please describe.

☐ Yes	☐ No	

ADDITIONAL INFORMATION

What are some of your strengths and accomplishments?

What are your goals for evaluation and therapy?

Please provide any additional information that might be helpful in the evaluation or remediation of your speech, language, fine motor, and/or sensory concerns.

AFFIRMATION OF INFORMATION

_____ I affirm that this packet has been completed accurately and to the best of my ability.

_____ I understand that I will receive an electronic copy of this form via email for my records.

_____ I understand that it is my responsibility to update my therapist with any changes to this form.

SIGNATURE OF PERSON COMPLETING FORM

Printed Name and Relationship:

Signature: Date:

SIGNATURE OF PATIENT (OVER THE AGE OF 18)

Printed Name:

Signature: Date: