Confidential Patient Information

Last Name: _____ **First Name:** _____ **MI:** _____ **Today's Date:** _____

Street Address: _____ **Apt/Suite/Unit #:**_____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Phone ***(Please include a check mark by your preferred number to be reached)*:**

☐ home ( ) _____-_____ ☐ work ( ) _____-_____ ☐ cell ( ) _____-_____

Gender: F / M **Age:** _____ **Date of Birth**: _____

Marital Status: ☐ single ☐ divorced ☐ married ☐ widowed

Significant Others name ***(people you live with or help in your care):*** _____

Adult Children: _____ **Minor Children:** _____ **Pets in home?** Y / N

Occupation: _____ **Employer:** _____

Do you have insurance that reimburses for Occupational Therapy Services? Y / N / UNSURE

Do you have Medicare Coverage? Y / N

Name of Insurance Company: _____

Phone Number to Insurance Provider: ( )_____-_____

Subscriber Number: _____ **Group Policy Number:** _____

Who may we thank for referring you? _____

What concern brought you to this clinic? _____

When did this problem start? _____

Does stress contribute to this problem from work, relationships, finances, self-esteem? _____

What have you already done to address this problem? _____

What makes the problem better? _____

What makes the problem worse? _____

What would you like to have happen as a result of our work together? _____

<u>Medical / Surgical History</u> ***(Please check all that apply)*:**

- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Broken bones/fracture
- ☐ Cancer(s)
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Infectious disease
- ☐ Kidney problems
- ☐ Lung problems
- ☐ Multiple Sclerosis
- ☐ Muscular dystrophy
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Presently pregnant
- ☐ Repeated infection
- ☐ Seizures/Epilepsy Circulation/ Vascular problems
- ☐ Skin diseases
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers/Stomach problems

History of any Surgery:
Please list all surgeries you have had in the past including ones you have fully recovered.

_____

Within the past year, have you had any of the following symptoms?

- ☐ Chest pain
- ☐ Difficulty sleeping
- ☐ Heart palpitations
- ☐ Loss of appetite
- ☐ Cough
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Weight loss/gain
- ☐ Coordination problems
- ☐ Urinary problems
- ☐ Weakness in arms or legs
- ☐ Hearing Problems
- ☐ Headaches
- ☐ Joint Swelling
- ☐ Difficulty walking
- ☐ Balance difficulties
- ☐ Uncorrected Vision problems?
- ☐ Fear of falling?

Have you fallen within the past year? YES / No If YES, about how many times? _____

Other concerns: _____

Current Daily Activities: ***(check activities you can't do or have made accommodations to do)***

- ☐ Self-Care
- ☐ Washing
- ☐ Dressing
- ☐ Toileting
- ☐ Showering
- ☐ Grooming
- ☐ Housework
- ☐ Meal prep
- ☐ Grocery shopping
- ☐ Household items shopping
- ☐ Mopping
- ☐ Bathrooms
- ☐ Kitchen
- ☐ Dusting
- ☐ Bedding
- ☐ Laundry
- ☐ Decluttering
- ☐ Garbage
- ☐ Windows
- ☐ Dusting/polishing
- ☐ Pet Care
- ☐ Yard Work
- ☐ Mowing
- ☐ Gardening
- ☐ Snow removal
- ☐ Auto maintenance
- ☐ Garage maintenance

Hobbies: _____

Physical Requirements of Employment: _____

Sport/Recreational activities: _____

Exercise: ***(describe frequency/duration/location)***_____

_____

Emotional Care Practices: ***(check all that apply)***

- ☐ Meditation
- ☐ Journaling
- ☐ Time with friends
- ☐ Nature
- ☐ Listening to music
- ☐ Prayer
- ☐ Support groups
- ☐ Other_____

_____

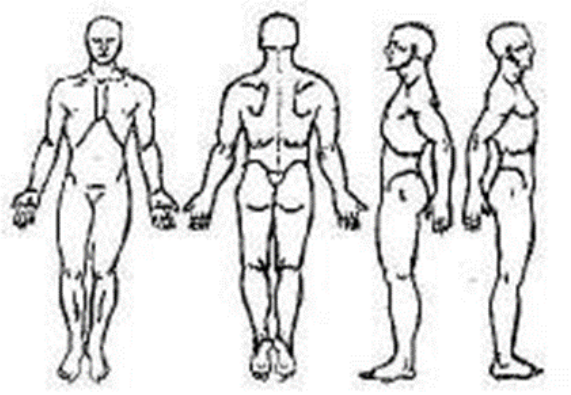
Are you on any Medications? Yes / No If yes, list medications: _____

_____

Pain:

Do you have pain? Yes / No

Pain location: ***(please shade in the area of your pain on the right)***



Pain Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Burning

☐ Ache ☐ Other:_____

Pain Frequency: ***(check all that apply)***

☐ Less than daily ☐ Daily ☐ Increases throughout the day
☐ Constant ☐ Night Pain ☐ Other: _____

What would you like to have happen as a result of our work together? _____

_____

Underline the range from the best you feel to the worst and circle the present intensity