



Advanced Therapy Care

Therapy Services for Children & Adults

New Patient Occupational Therapy Questionnaire - ADULT

PATIENT INFORMATION

Patient's Last Name:	First:	Initial:	Birthdate:
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Why are you being evaluated by Occupational Therapy?

Brief medical history:

Do you currently take any medications? If yes, please list

Do you have a history of the following? If yes, please explain

Developmental Delay/Disability Yes No

Traumatic Brain Injury Yes No

Cardiopulmonary Dysfunction Yes No

Hematologic D/O Yes No

Musculoskeletal D/O Yes No

Neuromuscular D/O Yes No

Burn Injuries Yes No

Infectious Conditions Yes No

Cancer Yes No

Diabetes Yes No

Birth Defects Yes No

Other: Yes No

Are you concerned about the way you use your body to do every-day tasks?

Yes No

Please describe your concerns:

Are there upper body (posture, shoulder, arm, head, and/or finger) concerns?

When and why did you become concerned about your movement abilities?

Do you have concerns related to eye/hand coordination? Yes No

If yes, please describe:

Are you concerned about the way you perceive the following sensory information?

- Auditory/Hearing Mouth/Oral
- Visual Touch/Tactile
- Balance

Are you over-reactive/sensitive or under-reactive to the above? (please describe)

Do you have any additional concerns not previously reported?
