# Advanced Therapy Care

Therapy Services for Children & Adults

## New Patient Occupational Therapy Questionnaire - ADULT

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Patient's Last Name: | First: | Initial: | Birthdate: |
| | | | |

**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 | |
| Aggression: | ☐ Yes ☐ No | (hitting, biting, kicking, punching, throwing objects) |
| 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?**