

CLIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

***Welcome to Occupational Therapy at Rusk County Memorial Hospital & Nursing Home***

Please fill out this form as thoroughly as possible. Should you have any questions or do not understand a statement please skip it and let your Therapist know so that he/she may provide clarification.

**Personal Information**

Have you ever been to Occupational Therapy before?  No  Yes—What for? \_\_\_\_\_

Do you smoke?  Yes  No  Previously smoked, but quit. Date quit \_\_\_\_\_

**Diagnostic Information**

Who referred you to Occupational Therapy? \_\_\_\_\_

When did your problem start/occur? \_\_\_\_\_

What is your Diagnosis/injury type? \_\_\_\_\_

Brief description of how the injury occurred \_\_\_\_\_

Next Physician's appointment \_\_\_\_\_  No appointment has been made at this time

Where do you work? \_\_\_\_\_  N/A

What is your job title or position? \_\_\_\_\_

Have you had x-rays, an MRI, or EMG? \_\_\_\_\_ Date \_\_\_\_\_

**Medical History**

Please list any and all medications that you are currently using:

Medication Name: \_\_\_\_\_ What is it for: \_\_\_\_\_

_____	_____
_____	_____
_____	_____

Please list any allergies, past or recent surgeries, and broken bones, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History**

Do you have a family history of any of the following? Please circle.

Arthritis      Cancer      Diabetes      Birth Defects      CHF      COPD  
Heart Disease

**continued on next page...**

**Functional Deficits (Day to Day Problems You Are Having With Your Injury/Diagnosis)**

**CLIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

1. Please list below any tasks or motions that you are having difficulty with doing/performing because of your injury/diagnosis.
2. Circle the level of difficulty you are having with performing these tasks.
3. Indicate the kind of pain you are having, on a scale of 0-10.  
(**0**=no pain, **5**=I usually need to take a pain pill, and **10**=I need to go to the emergency room due to the pain)

Activity	Level of Difficulty					Pain
Sample: Putting on socks and shoes.	None	Minimal	Moderate	Severe	Unable	4/10
1.	None	Minimal	Moderate	Severe	Unable	
2.	None	Minimal	Moderate	Severe	Unable	
3.	None	Minimal	Moderate	Severe	Unable	
4.	None	Minimal	Moderate	Severe	Unable	
5.	None	Minimal	Moderate	Severe	Unable	

**Client Goals**

After reviewing the areas of difficulty you are experiencing with your injury/diagnosis and how it has affected your lifestyle, what are some things that you would like to gain from being in Occupational Therapy?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

This is to aid in the selection of appropriate treatment exercises and tools to assist you in your recovery. In addition to the check off list, please add any items that you feel may be important for your treatment. Please circle **yes** or **no** as it applies to you.

**Do you have:**

- |     |    |   |
|-----|----|---|
| Yes | No | Any metal or artificial screws, joints, or fixations in your body?                    |
| Yes | No | Any shrapnel, bullet fragments in tissue or bone due to combat or other injury?       |
| Yes | No | A pacemaker?  |
| Yes | No | Pregnant or think you may be?   |
| Yes | No | Blood clots?  |
| Yes | No | Decreased ability to “feel” with your fingers?  |
| Yes | No | Decreased hearing, vision, taste, or smell? Please specify: _____                     |
| Yes | No | Tendency to bruise easily?  |
| Yes | No | Allergy to latex, or certain medical adhesive tapes?                                  |
| Yes | No | Osteoporosis, Cancer, HIV, AIDS, or any other transferrable diseases? (please circle) |

***Thank you for completing this form. Please return this to the receptionist and your Therapist will be with you shortly! 😊***