Sims Physical Therapy
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Occupational Therapy Intake

1. What is the reason you were referred to Occupational Therapy? _____
_____

2. What other treatments have been tried: _____

3. Did it help? □ Yes □ No If yes, how did it help? _____

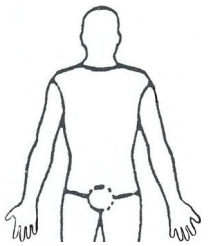
4. When is your next appointment with the referring physician? __/___/___

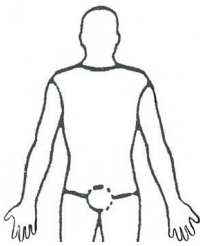
5. What is your occupation? _____
Describe the physical requirements of that job:_____
_____

6. What support do you have from your family/significant other/employer _____
_____

7. Onset of Problem:_____ Describe what happened: _____
_____ _____

8. Mark areas of pain:


Front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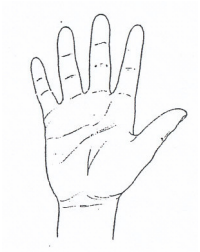

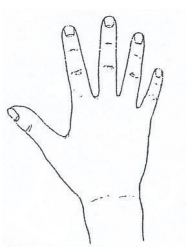

9. What activities increase your pain? _____

10. How are you able to relieve the pain? _____

11. Functional limitations:

Feeding self	☐ limited	☐Very limited	☐Unable to do	Cutting	☐ limited	☐Very limited	☐Unable to do
Dressing	☐ limited	☐Very limited	☐Unable to do	Fasteners	☐ limited	☐Very limited	☐Unable to do
Grooming	☐ limited	☐Very limited	☐Unable to do	Bathing	☐ limited	☐Very limited	☐Unable to do
Driving	☐ limited	☐Very limited	☐Unable to do	Work	☐ limited	☐Very limited	☐Unable to do

14. Have you ever had any of the following problems?

___ Heart Disease	___Kidney problems	___Fractures	___Bleeding Disorders
___ Diabetes	___Mental health	___Stroke	___Hepatitis C
___ Circulatory problems	___Cancer	___High Blood Pressure	

15. List any past surgeries: _____

16. Are you pregnant? ☐ Yes ☐ No

17. What benefits do you expect from Occupational Therapy?_____
_____
_____

Patient's Signature: _____