SALUS UNIVERSITY
Occupational Therapy Institute

Adult Intake Form

Client Information

Full Name: _____
Preferred Name: _____
Today's Date: _____
Date of Birth (dd/mm/yyyy): _____
Sex: _____

Check one or more options for the set(s) of pronouns you want people to use to refer to you:

- ❑ he, him, his
- ❑ she, her, hers
- ❑ they, them, theirs
- ❑ sie, hir, hirs
- ❑ Other: _____

Preferred Spoken/Written Language

- ❑ English
- ❑ Spanish
- ❑ American Sign Language
- ❑ Other: _____

Language interpretation services needed?

- ❑ No
- ❑ Yes, language: _____

Preferred Email: _____
Preferred Mailing Address: _____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No

Name of person filling out the form if other than client: _____
Relation to client: _____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Marital Status:

- ❑ Single
- ❑ Engaged
- ❑ Married

- ❑ Separated
- ❑ Widowed
- ❑ Divorced
- ❑ Other: _____

Caretaker's Name: _____
Phone Number: _____

Employment (if applicable): _____
Current Occupation: _____
Employer: _____

Doctor Information
Primary Care Physician: _____
Phone Number: _____

Referral Information
Who referred you/the client to our clinic? _____
Reason for referral: _____

What are your primary concerns?
_____
_____
_____

What do you hope to accomplish with therapy services?
_____
_____
_____

Do you have Health Insurance, Medicaid, or Medicare? ❑ Yes ❑ No

- ❑ Insurance Company: _____

Is your reason for seeking services related to an automobile accident or work injury?

- ❑ No
- ❑ Yes, if so, please provide more information_____

If YES, why are you accessing pro bono services?

- ❑ Copays are too high
- ❑ Exhausted Insurance
- ❑ Other:_____

This section is optional to complete:

Are you of Hispanic, Latino, or of Spanish origin? ❑ Yes ❑ No
How would you describe yourself? Check all that apply.

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ From multiple races
- ❑ Other: _____

Emergency Information Sheet
Client Full Name:_____ Birthdate:_____
Phone Number: _____
Contact Name: _____ Relation: _____
Work Phone Number: _____
Cell Phone Number: _____

If client becomes ill or involved in an accident and an emergency contact cannot be reached, I authorize the following hospital or above-named physician to give the emergency medical treatment required:
Hospital: _____ Address: _____
Signature: X_____
Date:_____

Medical History:

Are you currently pregnant or breastfeeding? _____
Do you have any allergies to medications or other substances (pets, food, etc.)? ❑ Yes ❑ No
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):
_____
_____
_____

Please check any of the following services that the client currently receives or as received in the last 6 months:

- ❑ Mental Health Counseling
- ❑ Substance Abuse Counseling/Treatment
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Speech Language Pathology
- ❑ Vision Therapy
- ❑ Audiology Services

- ❑ Other: _____

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
When was your last comprehensive medical evaluation? _____

Please check any of the following diagnoses which you are currently, or previously received treatment for:

- ❑ Developmental Disorder
  - ❑ Autism Spectrum Disorder
  - ❑ Down Syndrome
  - ❑ Other:_____
- ❑ Psychosocial
  - ❑ Anxiety
  - ❑ Depression
  - ❑ OCD
  - ❑ Eating Disorder
  - ❑ Other:_____
- ❑ Cancer
  - ❑ Type/location:_____
- ❑ Neurological Disease/Disorder
  - ❑ Spina Bifida
  - ❑ Alzheimer's/Dementia
  - ❑ Parkinson's Disease
  - ❑ Multiple Sclerosis
  - ❑ Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease
  - ❑ Seizure Disorder
  - ❑ Frequent Headaches/Migraines
  - ❑ Head Injury/Concussion
  - ❑ Stroke, if so when_____
  - ❑ Other:_____
- ❑ Obesity
- ❑ Diabetes
  - ❑ Type 1
  - ❑ Type 2
- ❑ Vision Impairment
- ❑ Auditory impairment
- ❑ Heart/Pulmonary/Vascular
  - ❑ Heart attack, if so when_____

- ❑ Pacemaker
- ❑ COPD
- ❑ Cystic Fibrosis
- ❑ Asthma
- ❑ Orthostatic hypotension
- ❑ Clotting/bleeding disorder
- ❑ Sickle Cell Anemia
- ❑ Pulmonary Embolism/DVT
- ❑ Blood clots
- ❑ Anemia
- ❑ Other:_____

❑ Degenerative Disease
❑ Stomach Problems
❑ Falls
❑ Neuromuscular

- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Muscle/Tendon injury
- ❑ Muscular Dystrophy
- ❑ Joint Replacement
- ❑ Fractures; when and where_____
- ❑ Other:_____

❑ Pain
❑ Sleep problems
❑ Other: _____

Are you currently taking any medications/supplements/vitamins? ❑ Yes ❑ No

Medications:

_____
_____
_____

Supplements/Vitamins:

_____
_____
_____

Is there anything else you would like your occupational therapist to know before your evaluation or screening (ex. prior developmental difficulties, medical complications, personal preferences)?

_____
_____
_____

Optional:
Do you think anyone else in your household/residence would benefit from services?

- ❑ No
- ❑ Yes
    - ❑ If so please list, _____

Thank you for providing this information
Additional comments/personal or family history:

_____
_____
_____

____Notice of Client Rights & Responsibilities: I acknowledge that I have received and read a copy of the Client Rights and Responsibilities form.
____Notice of Privacy Practices: I acknowledge that I have received and read a copy of the Notice of Privacy Practices that describes my rights regarding my health information and how my health information may be used or disclosed.
____Authorization to Release Medical Information: I authorize the Occupational Therapy Institute to release my medical information to my referring physician or nurse practitioner in order to coordinate care.
____Consent to Treat: I give my consent to the Occupational Therapy Institute students and licensed supervisors to provide outpatient therapy services considered necessary and proper for my diagnosis. I understand that I may refuse treatment at any time. My initials above and my signature below indicate consent to all of the above.
____Consent to Treat: I understand that I can be treated at the Occupational Therapy Institute for two consecutive semesters, followed by a break in care for one semester. This is to provide equity for other patients on the waitlist, and to provide patient diversity for student learning. If appointments become available during my break period, I may be offered another evaluation as time allows.
____ Consent to Treat: I understand that I need a new prescription every semester (January, May, and September) to continue my plan of care at the Occupational Therapy Institute.
____ Consent to Treat: I understand that I may be discharged from the Occupational Therapy Institute if more than three sessions in a three months period are canceled or not attended (i.e. no show) without notice to the clinic staff.

Release for educational and teaching purposes

I, _____, authorize the therapists at the Occupational Therapy Institute, to be observed and or receive therapy during sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

Signature: _____
Patient Name:_____
Date:_____