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:

_____
_____
_____