703-910-5006 www.CreativeHealthLLC.com INFO@CreativeHealthLLC.com

(Adult) Initial Consultation Questionnaire

Client's Name:_____ Gender:____ Date:__/____/_____

Date of Birth: __/____/_____ Age:_____yrs.

Referred by:_____

Responsible party (if not client):_____

Address:_____

Telephone: Cell_____ Home _____ Work _____

Email:_____ Fax#_____

Name of person completing this form:_____

Relationship to client:_____

MEDICAL HISTORY

Name of Primary Care Physician & Practice name: _____

_____

Physician's Specialty_____

Phone _____ Fax _____ Email _____

Address:_____

Date of last examination: __/____/_____ Date of next appointment: __/____/_____

Current medications and/or remedies prescribed:

1)_____ Start Date __/____/_____ Purpose_____

_____

2)_____ Start Date __/____/_____ Purpose_____

_____

3)_____ Start Date __/____/_____ Purpose_____

_____

Prescribed by:_____

Have you ever been hospitalized? (Circle one) YES NO

Hospital	Month/Year	Reason
_____	____/_____	_____
_____	____/_____	_____
_____	____/_____	_____

Do you currently have a medical diagnosis? YES NO

If so, please specify: _____

_____

_____

_____

Describe any important medical history, chronic ailments, or other health problems that you has experienced, not listed above: _____

_____

_____

_____

Do you have any close relatives (father, mother, sister, brother, grandparent) who have similar medical histories? Please list:_____

_____

_____

_____

_____

Please list any other specialists that you have seen, noting those that are current.

_____

_____

_____

_____

_____

_____

Do you receive Speech/Language Therapy Services? YES NO

Name of therapist_____ Telephone #_____

Do you receive Physical Therapy Services? YES NO

Name of therapist_____ Telephone #_____

Do you receive Occupational Therapy Services? YES NO

Name of therapist_____ Telephone #_____

NEURO-PHYSIOLOGICAL STATUS

Please check any of the following disturbances that describe how you believe you have been feeling lately and explain below:

_____sad _____anxious _____depressed _____frightened _____guilty _____angry

_____ashamed _____aggressive _____resentful _____worthless _____tearful _____irritable

_____confused _____extreme ups/downs _____jealous _____hopeless

_____

_____

_____

_____

_____

_____

_____

Describe any problems which have occurred in your life related to trauma, stress and/or abuse:_____

_____

_____

_____

What are your sleeping habits like? Include any recent changes.

_____

_____

_____

What are your eating habits like? Include any recent changes.

_____

_____

_____

_____

What makes you laugh?_____

_____

_____

_____

What do you do when angry, frustrated, or overwhelmed?

_____

_____

_____

_____

How do you calm yourself down?_____

_____

_____

_____

_____

Please, briefly, describe any issues or sensitivities you may have that involve:

Hearing: _____

_____

_____

_____

_____

Touch: _____

_____

_____

_____

_____

Smelling: _____

_____

_____

_____

_____

Mouthing/Eating: _____

_____

_____

_____

_____

Movement: _____

_____

_____

_____

_____

Vision: _____

_____

_____

_____

_____

RECREATION

What are your favorite activities, games, or hobbies?_____

_____

_____

_____

_____

_____

_____

_____

LEVEL OF FUNCTIONING

Please list any accommodations that you currently use to help with participation in daily activities. (visual schedules, calendars, sensory diet, equipment, etc.)

_____

_____

_____

_____

Please describe your level of physical activity:_____

_____

_____

How much time every day are you using the computer_____, watching TV_____, or using other technology_____?

_____

_____

_____

Please describe activities that cause discomfort or pain. Rate the level of pain on a scale of 1-10 with 10 being the worst:_____

_____

_____

_____

_____

_____

_____

_____

TREATMENT PLANNING

What do you consider to be your greatest strengths?_____

_____

_____

What do you consider to be your greatest challenges?_____

_____

_____

Any other comments that might be helpful to us?_____

_____

_____

Please list your therapy goals:_____

_____

_____

_____

_____

_____

_____

Your Name_____ Date:___/____/_____

Please provide this information, along with copies of any previous evaluations, educational plans or other reports that you would like the therapist to consider when assessing and treating you.

Thank you so much for taking the time and effort to fill out this lengthy form.

Judy D Feingold OTR/L

_____ **Date:____/____/_____**