703-910-5006 www.CreativeHealthLLC.com
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Home Assessment 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:____

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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.

____

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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 #_______________

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. (adaptive equipment, environmental modifications, assistive devices, such as reachers, sockaides, grab balls, 3-in-1 commode, cane, rollator, etc)

____

____

____

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____

____

Do you drive? ____

Do you require assistance with daily activities (dressing, bathing, toileting, grooming, etc)

____

____

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Please describe your level of physical activity:_________________________________

____

____

____

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

____

____

____

____

In recent weeks have there been any areas of your home specifically difficult to access? Please describe:____

____

____

____

____

HOME ENVIRONMENT

Are there steps to enter the home? If so, how many?____________________________

Do you use more than one entrance to the home? If so, please indicate the number of steps at the alternative entrance(s)?____

Please describe the general layout of the home (e.g., split-level, single floor, etc)

____

____

____

____

What floor is the master bedroom and mainly used bathroom(s)?__________________

Is your mainly used bath a walk in shower or a tub?_______________________________

Are there steps inside the house? If so, how many?________________________________

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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 important form.

Jackie Bauer MOT, OTR/L

_________________________ **Date:___/___/____**

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