



**703-910-5006 [www.CreativeHealthLLC.com](http://www.CreativeHealthLLC.com)  
[INFO@CreativeHealthLLC.com](mailto: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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When and where was your last vision test. \_\_\_\_\_

Findings? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your your hearing been tested? \_\_\_ If so, where \_\_\_\_\_

Findings? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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? \_\_\_\_\_

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## 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.)

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Please describe your level of physical activity: \_\_\_\_\_

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How much time every day are you using the computer \_\_\_\_\_, watching TV \_\_\_\_\_, or using other technology \_\_\_\_\_?

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

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**TREATMENT PLANNING**

What do you consider to be your greatest strengths? \_\_\_\_\_

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What do you consider to be your greatest challenges? \_\_\_\_\_

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Any other comments that might be helpful to us? \_\_\_\_\_

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Please list your therapy goals: \_\_\_\_\_

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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:** \_\_/\_\_/\_\_\_\_