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

(Transition to Independence) 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: __/____/_____

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: _____

_____

_____

_____

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

_____

_____

_____

_____

_____

NEURO-PHYSIOLOGICAL STATUS

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

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

How do you calm yourself down?_____

_____

_____

_____

_____

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:_____

_____

_____

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

_____

_____

_____

_____

_____

EMPLOYMENT

Are you currently working?_____ If so, how many hours per week?____ If not, where are you interested in working or volunteering?_____

_____

Have you held jobs in the past?_____ If so, where? _____

_____

_____

If so, what did you like or dislike about your job(s)?_____

_____

_____

What kind of job do you think you would like?_____

_____

_____

Describe your ideal job:_____

_____

_____

What are your interests, hobbies, etc?_____

_____

What are you goals for employment and independent living?_____

_____

_____

How do you perform with a team (leader, work well with others, directive, etc)?_____

_____

_____

TRANSITIONING, EDUCATION, AND DAILY LIFE

Have you/are you using any resources for transitions (eg, IEP transition plan, DARS, etc)?

_____

_____

_____

If so, what has worked and not worked for you regarding these programs? _____

_____

_____

_____

What classes did you enjoy in school?_____

_____

_____

Do you want to continue your education?_____ If so, in what area? _____

_____

_____

Where would you be interested in living (city with stores close by, suburban, rural)?_____

_____

_____

What kinds of transportation do you use (bus, car, Metro)?_____

_____

Describe your typical day: _____

_____

_____

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:_____

_____

_____

_____

_____

_____

_____

Signature_____ 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.

Therapist:_____

Signature:_____ Date:____/____/_____