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:____

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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:____

____

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____

____

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

____

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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

____

____

____

____

____

____

____

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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:

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Hearing: ____

____

____

____

____

Touch: ____

____

____

____

____

Smelling: ____

____

____

____

____

Mouthing/Eating: ____

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____

____

Movement: ____

____

____

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____

Vision: ____

____

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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:____

____

____

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____

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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 lengthy form.

Judy D Feingold OTR/L

___________________________ **Date:___/___/_____**

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