



Physical and Occupational Therapy Intake

Date Completed: ____/____/____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Sex: Male Female Nickname: _____

Primary Language: _____ Secondary Language: _____

Referral Information

Note: Many standardized tests cannot be repeated within one year. Please be sure to bring or send a copy of any previous physical or occupational therapy evaluations done within the last year.

- I am requesting the following: A physical therapy evaluation
 An occupational therapy evaluation

What is it that you would like for us to look at? What would you like to get out of the evaluation(s)?

Has the patient has participated in physical or occupational therapy for this reason in the past? Yes No

If yes, Physical Therapy? Occupational Therapy?

Was the patient discharged from this therapy? Yes No

Please explain:

Clinical Information

Has the patient had any recent major falls? Yes No

If yes, please describe.

Does the patient have any major complaints of pain? Yes No

If yes, please describe including location.

What are your current motor concerns?

PTOT/2

Does the patient have difficulty with coordination?

Yes No

If yes, please describe.

Does the patient have any trouble holding or using small objects or with handwriting?

Yes No

If yes, please describe:

Indicate the patient's level of independence with activities of daily living.

Task	Unable to do	Some Assistance Needed	Independent
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming/Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the patient have decreased safety awareness? (i.e. climbing head first out of structures, bolting, taking excessive risks)

Yes No

If yes, please describe:

Does the patient have an increased activity level or distractibility?

Yes No

If yes, please describe:

Does the patient seem over or under aroused to certain types of input?

Yes No

If yes, please indicate below "seeks" or "avoids" for all that apply.

Input		Input	
Oral	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>	Gustatory (taste)	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>
Tactile (touch)	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>	Proprioceptive (body awareness)	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>
Auditory	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>	Vestibular (movement)	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>
Visual	Seeks <input type="checkbox"/> Avoids <input type="checkbox"/>		

Do you have any current sensory concerns or observations?
