SPAULDING OUTPATIENT CENTER LEXINGTON

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?

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	☐	☐	☐
Feeding	☐	☐	☐
Toileting	☐	☐	☐
Grooming/Bathing	☐	☐	☐

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 ☐ Avoids ☐	Gustatory (taste)	Seeks ☐ Avoids ☐
Tactile (touch)	Seeks ☐ Avoids ☐	Proprioceptive (body awareness)	Seeks ☐ Avoids ☐
Auditory	Seeks ☐ Avoids ☐	Vestibular (movement)	Seeks ☐ Avoids ☐
Visual	Seeks ☐ Avoids ☐		

Do you have any current sensory concerns or observations?