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ADULT CASE HISTORY FORM

Occupational Therapy

Please fill out this form as completely as possible. The information will help us understand your present fine motor/gross motor problem(s) and will aid us in planning appropriate testing procedures. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

***Please Note after completion of this form please along with any other pertinent information regarding your motor history (hospital records, doctors reports, etc.)**

(Please Print or Type)

Client's Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

E-Mail Address: _____

Date of Birth: _____ Sex: ____ Age: ____ SSN: _____

Marital Status: **S M D W**

Ethnicity: **African American – Asian – Caucasian – Hispanic/Latino Other** _____

Employer: _____ Employer Phone: _____

Name of Spouse: _____

Spouse Employer: _____ Employer Phone: _____

Combined Income *(Please check one)*

| | | |
|------------------------|-----------------------|------------------------|
| Less than \$12,000 ___ | \$30,000-\$50,000 ___ | \$90,000-\$120,000 ___ |
| \$12,000-\$20,000 ___ | \$50,000-\$70,000 ___ | over \$120,000 ___ |
| \$20,000-\$30,000 ___ | \$70,000-\$90,000 ___ | |

How did you hear about us? *(Please circle one)*

Word of Mouth Phone book/yellow pages Internet Physician
Other _____

If Physician, please list name: _____

Reason for Referral: _____

**If you do not want to receive information about new services, fundraising events
Or other BRSH news, please check here**

Fine and Gross Motor History

Please mark if you have a history of difficulty with any of the following:

| <u>Symptoms</u> | <u>Never</u> | <u>Rarely</u> | <u>Frequently</u> | <u>Date of Last Incidence</u> |
|--|--------------|---------------|-------------------|-------------------------------|
| Hand or arm weakness | | | | |
| Hand or arm pain | | | | |
| Difficulty with clothing fasteners | | | | |
| Difficulty getting dressed | | | | |
| Difficulty with bathing/getting out of shower | | | | |
| Trouble holding a pencil | | | | |
| Difficulty with writing | | | | |
| Difficulty with Typing | | | | |
| Difficulty organizing your daily routine | | | | |
| Difficulty remembering your daily routine | | | | |
| Difficulty cooking | | | | |
| Loss of balance when walking around your house | | | | |

What are your goals for therapy? *(Please be specific)*: _____

Have you had previous occupational therapy for this current problem? Please explain:

Does the above problem get in the way of your every day routines? Please explain:

Has this problem improved/deteriorated since the onset? Please explain:

HEALTH HISTORY

Please mark any of the following disorders that you have experienced.

| Disorders | Never | Rarely | Frequently | Date of onset | Date of last Incidence |
|---|-------|--------|------------|---------------|------------------------|
| Allergies/ Sinusitis | | | | | |
| Hand/Arm Numbness | | | | | |
| Stroke/TIA's | | | | | |
| Illness/High Fever | | | | | |
| Heart Disease/ Atrial Fibrillations | | | | | |
| Head Trauma | | | | | |
| Reflux/Heartburn | | | | | |
| Hypertension | | | | | |
| COPD | | | | | |
| Pneumonia | | | | | |
| Injury/Falls | | | | | |
| Surgery | | | | | |

If you have had treatment for any of the above disorders, please describe:

Were you hospitalized for this condition? (Include Dates and Names of Hospitals.)

Please list all medications you are currently taking and the reason for which they have been prescribed along with any side effects:

| MEDICATION | REASON taking MEDICATION | SIDE EFFECTS (Please specify) |
|-------------------|-------------------------------------|--|
| | | |
| | | |
| | | |
| | | |
| | | |

Name of Insurance and Address: _____

Policy #: _____ Named Insured: _____

Medicare # _____ Medicaid #: _____

Person responsible for payment: _____

Signature of Responsible Party: _____

Date: _____

Name of person completing this form: _____

Relationship to Client: _____ Phone: _____