Stony Brook Medicine

HISTORY FORM: OCCUPATIONAL THERAPY

Age: _____ Male/Female Hand Dominance: Right/Left/Both

Highest Education Level: _____ Occupation: _____

Current Work Status? _____

What was your work status prior to your current condition? _____

List your leisure activities/hobbies/sports _____

Do you have any difficulties with: ___ vision ___ hearing ___speech/language? If so, please explain_____

_____

HISTORY OF PRESENT ILLNESS

What problem(s) brings you here today? _____

When did this problem begin? _____ Did this occur gradually or suddenly? Please Describe_____

_____

Were you hospitalized for this condition? Yes/No If yes when, for how long, & where_____

_____

Since this problem began have your symptoms __improved __worsened __stayed the same

What Diagnostic tests/ procedures have you undergone for this problem (ie x-rays, MRI, EMG, surgery)? _____

Please list results/findings: _____

Have you received any other treatment for this condition (i.e. OT, PT, injections). Yes / No If yes describe type of treatment, dates received _____

What activities increase your symptoms: _____

What activities decrease your symptoms:_____

What is your pain level: Pain at Rest_____ Pain With Activity_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Where is your Pain _____

Quality of Pain is: ___sharp ___ dull ___throbbing ___numbness __tingling __shooting __burning __other_____

Frequency of Pain: __constant (76-100%) __frequent (51-75%) __ occasional (26-50%) __rarely (25% or less)

Please list all medications you are currently taking_____

_____

PAST MEDICAL HISTORY Do you have/had any of the following medical conditions?

__ Heart Condition_____ __ Kidney Disease_____

__ High Blood Pressure_____ __ Arthritis_____

__ Cancer_____ __ Angina_____

__ Seizure Disorder_____ __ Vascular Disorder_____

__ Osteoporosis_____ __ Diabetes_____

List any allergies and reactions_____

List any other medical conditions or surgeries (pregnancies, injuries, etc.)_____

_____

Please continue on next page

Stony Brook Medicine

PATIENT HISTORY FORM: OCCUPATIONAL THERAPY (continued)

FUNCTION

What problems resulting from your current condition are limiting your ability to participate in your activities

_____

Are there any techniques or assistive devices that you currently use to help you complete your daily activities? _____

_____

Check the following activities you are having any difficulty with because of your current condition?

Check		Briefly describe
	DRESSING	
	EATING	
	GROOMING/HYGIENE	
	KITCHEN ACTIVITIES	
	BATHROOM ACTIVITIES	
	HOUSEKEEPING	
	YARDWORK	
	HOMEMANAGEMENT	
	MONEY/BANKING ACTIVITIES	
	WRITING	
	HANDLING COINS, KEYS, etc.	
	TELEPHONE USE	
	USE OF TOOLS	
	SHOPPING	
	TIME MANAGMENT	
	WORK/SCHOOL TASKS	
	SOCIAL ACTIVITIES	
	MOBILITY	
	LEISURE ACTIVITIES	
	COMPUTER	
	READING	
	OTHER	

Do you live alone: Yes/No If no, who do you live with: _____

Do you have any assistance at home: _____

GOALS

Please list your goals/what you hope to accomplish in occupational therapy (include functional activities)

_____

Patient Signature_____

FOR THERAPIST USE ONLY

Comments_____

_____

_____

Above report reviewed with patient for accuracy. **Therapist Signature**_____

_____