Occupational Therapy
For All Ages

HAND IN HAND
ConnectedOT
WE ACHIEVE.

Adult Occupational Therapy Intake Form

TODAY'S DATE

CLIENT INFORMATION

FULL NAME

DATE OF BIRTH AGE

GENDER
☐ Male ☐ Female ☐ Other _____

ADDRESS

PHONE NUMBER

EMAIL ADDRESS

PREFERRED METHOD OF CONTACT
☐ Phone ☐ Email

EMERGENCY CONTACT INFORMATION

FULL NAME | RELATIONSHIP TO CLIENT | PHONE NUMBER

REFERRAL INFORMATION

REFERRED BY ____ Self ____ Family/Friend ____ Physician ____ Other _____

NAME OF REFERRER (IF APPLICABLE)

REASON FOR REFERRAL:

Sonya Tcherevkoff, M.S., OTR/L

Therapeutic & Family Services, Consultations,Mind/Body Wellness, Case Management

www.Connected-OT.com

MEDICAL HISTORY

PRIMARY PHYSICIAN'S NAME

PHYSICIAN'S PHONE NUMBER

Current Medical Conditions (e.g., Diabetes, Hypertension, etc.)

History of Surgeries or Hospitalizations

Medications Currently Taking

Allergies (Including Medications)

REASON FOR SEEKING OCCUPATIONAL THERAPY

Describe the challenges you are experiencing

How long have you been experiencing these challenges?

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Have you received Occupational Therapy before? ☐ Yes ☐ No

IF YES, WHEN AND WHERE? _____

What are your goals for Occupational Therapy?

DAILY LIVING ACTIVITIES

Do you have difficulties with any of the following? (check all that apply)

☐ Dressing ☐ Eating ☐ Household Chores ☐ Work Tasks ☐ Leisure Activities
☐ Bathing ☐ Mobility ☐ Communication ☐ Cooking
☐ Other _____

PSYCHOSOCIAL HISTORY

Living Situation ☐ Alone ☐ With Family ☐ Assisted Living ☐ Other _____

Emplyoment Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Hobbies/Interests _____

Support System (e.g., family, friends, community groups):

CONSENT AND AUTHORIZATION CONSENT AND AUTHORIZATION

I hereby consent to participate in Occupational Therapy services provided by Connecte OT. I authorize the release of necessary medical information to my insurance provider for billing purposes.

PRINT NAME _____ SIGNATURE _____ DATE _____