allcare Therapy Services, LLC
OCCUPATIONAL, SPEECH, PHYSICAL & ABA THERAPY

ADULT INTAKE PACKET

Date of evaluation: _____

Patient Information:

Name: _____ Email Address:_____

Address: _____

City/State/Zip: _____

Social Security #: _____Date of Birth:_____

E-Mail Address: _____

Marital Status: _____ M _____ S _____ D _____ W

Specialty Doctor/Phone: _____ Fax #: _____

Primary/Family Physician & Phone: _____ Fax #: _____

Employer & Address: _____

Work Status: _____ FT _____ PT _____ Retired _____ Student _____ Unemployed _____ Disabled _____

Gender: _____ M _____ F DOB: _____ Body Part: _____

RX Date: _____ Diagnosis: _____

Date of Injury/Onset: _____

Emergency Contact Name: _____ Phone #: _____

Past Medical History Questionnaire:

Reason for Therapy: _____

Date of Injury or Onset: _____

Have you ever received therapy for the condition mentioned above? _____

If so, when? _____

Treatment received: _____

Previous Treatment: □ Successful □ Unsuccessful Can you be/are you pregnant?: □ Yes □ No

Do you now or have you ever had any of the following?

Condition:	***Yes***	***No***	***Condition:***	***Yes***	***No***
Arthritis	□	□	Hearing Loss	□	□
Osteoporosis	□	□	Depression	□	□
High Blood Pressure	□	□	Anxiety	□	□
Heart Disease	□	□	Substance Abuse	□	□
Heart Attack	□	□	Diabetes	□	□
Pace Maker	□	□	Anemia	□	□
Vascular Disease	□	□	Hypersensitivity to Hot/Cold	□	□
Stroke	□	□	Swelling in Ankles	□	□
Asthma	□	□	Deep Vein Thrombosis (DVT)	□	□
Shortness of Breath	□	□	Seizures/Epilepsy	□	□
Chronic Cough	□	□	Metal in Body/Surgical Implants	□	□
Fainting Spells	□	□	Cancer/Tumor	□	□
Thyroid Problems	□	□	Recent Weight Loss/Gain	□	□
Headaches	□	□	Current Infection(s)	□	□
Head Injury/Concussion	□	□	Tuberculosis	□	□
Hernia	□	□	Hepatitis	□	□
Kidney/Previous Fractures	□	□	Other:	□	□
Previous Surgeries	□	□			

If you answered "yes" on any of the above, please explain and give approximate date(s):

_____

Do you have any allergies: □ No □ Yes, list allergies:

_____

Are you presently taking any medications?: □No □ Yes, list medications and specify condition(s):

_____

Communication & Language Use:

Uses Words: □ No □ Yes

Uses Sentences: □ No □Yes

Relies on Gestures: □ No □ Yes

Relies on other means of communication: □ No □ Yes

If yes, describe: _____

Omits small words (of, the, and, etc.): □ No □ Yes

Words that seem to be difficult: _____

Easier words: _____

Most difficult communication activities: _____

Do family members try to fill in words or talk for client? □ No □ Yes

Do family members anticipate or guess client's needs by communicating? □ No □ Yes

Makes change or handles money: □ No □ Yes

Follows simple requests or instructions: □ No □ Yes

Gets lost in conversations or complicated instructions: □ No □ Yes

Understands TV or radio: □ No □ Yes

Reads/Understands newspaper: □ No □ Yes

The information is correct to the best of my knowledge.

X: _____

Signature of Patient/Legal Guardian