OCCUPATIONAL THERAPY INTAKE

CLIENT INFORMATION

Name: _____

Address: _____
_____

How did you hear about OT services?
_____

_____

Date or birth:_____

Age: _____

Do you give consent to start assessment process? Y / N

Occupation: _____

Diagnosis/precipitating events:

_____

_____

_____

_____

What issues are you looking to have resolved?

_____

_____

_____

_____

Medications: _____

_____

I. ENVIRONMENT

What type of dwelling do you live in? Do you have any problems moving around in your home? (apartment, 2 storey house, etc)

_____

_____

Support system

Family context (married, single, children, pet, etc):

_____

Community support (support groups, volunteer, religious groups, social meetings, etc):

_____

_____

Name some things that you value: (spending time with family, respect, integrity, etc)

_____

_____

Date:	**Signature:**

Occupational Therapist

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I. SELF CARE AND PRODUCTIVITY

In the following chart tick the appropriate box to indicate your level of independence in doing the following activities of daily living**.**

Legend:
I = independent (I am able to do the activity by myself without cuing)

S=supervision (I need someone or something to remind me)

A=assistance (I mostly do the activity but someone helps me do the activity – mark who in the comments)

D=dependent (I am unable to do this for myself and require someone else to do it for me completely)

N/A= not applicable

Are you able to:	I	S	A	D	N/A	Comments
Bathe yourself						
Dress (indoor clothing)						
Dress (outdoor clothing)						
Use the toilet						
Feed yourself						
Groom (brush hair, teeth, shave)						
Mobility (walk around) If you use a cane or walker then mark A						
	I	S	A	S	N/A	Comments
Meal preparation						
Housecleaning						
Laundry						
Shopping						
Medication						
Budget						
Telephone						
Transportation (driving, public transport)						

Date:	**Signature:**

Occupational Therapist

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How do you spend a typical day from the moment you get up to the moment you go to bed?

_____

_____

_____

_____

Communication Skills:

Any difficulties with written Communication?

_____

_____

Any difficulties with Oral Communication?

_____

_____

What are your Leisure/Hobbies? _____

_____

Career goals? _____

III. PERFORMANCE COMPONENTS

Check all that apply

Cognition - Any problems with:

____Attention/concentration
____Organization/time management
____Frustration tolerance
____Impulsivity
____Long term memory
____Short term/working memory
____Problem solving
____Judgement
____Planning
____ Other _____

Date:	**Signature:**

Occupational Therapist

Psychological and emotional

Any feelings of depression or anxiety? If yes, describe

_____

_____

_____

Any mental health or addictions issues? If yes, describe

_____

_____

_____

What do you do to help you relax? _____

_____

How is your mood?

_____

How are your relationships with your family and friends? _____

_____

_____

Any problems with the law? If yes, describe

_____

_____

Spiritual

What spiritual practices, activities, or beliefs give you strength? _____

_____

If you had 3 wishes, what would you change about your life? _____

_____

_____

Date:	**Signature:**

Occupational Therapist

Physical

Check all that apply

Any problems with:

____Upper extremity range of motion
____Lower extremity range of motion
____Balance
____Endurance
____Strength
____Coordination
____ using your hands

Are you:
□ Right Hand Preference
□ Left Hand Preference

Sensory functions – List any difficulties with:

Vision _____

Hearing _____

Touch _____

Smell _____

Taste _____

Awareness of your body in space (bumping into things) _____

Do you have any pain? If yes describe location, frequency and intensity _____

_____

_____

Are there any other things that you would like to add?

_____

_____

_____

Date:	**Signature:**

Occupational Therapist