Maureen Brady OTR/L

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Seattle, WA 98134

Occupational Therapy Intake Form

Name: _____ Today's Date: _____

Nickname: _____ DOB: _____

Referred to OT by: _____

Diagnosis (If known) and Practitioner who complete the evaluation (Please provide this documentation):

_____

Please list individuals and your relationship to those you reside with.

_____ _____

_____ _____

_____ _____

Language spoken in the home: _____

Is an interpreter needed for the Occupational Therapy session? _____

Emergency contact person: (Name) _____

Phone number(s) _____

Primary Doctor's name and address: _____

_____

_____

Occupational Therapy Intake Form, page 2

Have you received Occupational Therapy in the past? _____ Yes _____ No

Are you currently seeing other practitioners, i.e., Naturopaths, Functional Medicine Doctors, Counselors, Neurologists, Nutritionists, Psychologists, etc.? _____ Yes _____No

If yes, please list the practitioner's name(s) and address:

_____ ____

_____ ___

_____ ___

Please list all medications and supplements you are currently taking.

_____ ___

_____ ___

_____ __

_____ __

_____ ___

Are there any medical concerns that the OT should be aware of? _____ Yes _____ No
If yes, please list these. _____ __

_____ __

_____ __

Have you ever been tested for allergies? _____ Yes _____No

If yes, please list practitioner and how testing was done, i.e., blood test, muscle testing, etc.

_____ ___

Occupational Therapy Intake Form, page 3

Do you have any allergies? _____ Yes _____ No If yes, please list these.

_____ __

Are there currently any changes or stressors occurring in your life?

_____Yes _____ No If yes, please explain.

_____ ___

_____ __

_____ __

Do you have any specific phobias or anxieties? _____ Yes _____ No

If yes, please list them.

_____ _

_____ _

_____ _

Please list your primary reason(s) for requesting OT and your desired outcome(s).

_____ _

_____ _

_____ _

_____ _

Printed name of person competing this form.

_____-_