BRONSON

Bar Code Here

Affix Patient Label

Patient Name Date of Birth

Please complete this form before you see the therapist. This information will help the therapy team to better understand your current condition and how we can work together to best meet your needs.

The following individuals have my consent to pick up or accept phone calls regarding my schedule: ☐ None

Please list: _____

What grade did you complete at school? _____

Occupation: _____

Do you live alone? ☐ No ☐ Yes

What are the problems that bring you to therapy today?_____

Date of Accident/Injury_____

Indicate any symptoms you have experienced as a result of this accident.

☐ Behavior/Mood changes	☐ Depression	☐ Dizziness	☐ Headache
☐ Hearing Loss	☐ Loss of Consciousness	☐ Memory Loss	☐ Seizures
☐ Sensitivity to light	☐ Sensitivity to Sound	☐ Vision Changes	☐ Change in appetite
☐ Difficulties at work	☐ Difficulties at school		

Do you have pain? ☐ No ☐ Yes

If yes, pain is located: _____

Have you had past treatment for this problem or similar problems? ☐ No ☐ Yes

What makes you feel worse?

_____

What makes you feel better?

_____

I need help for the following activities:

☐ Bathing	☐ Dressing	☐ Driving	☐ Housework	☐ Making a phone call
☐ Meal preparation	☐ Shopping	☐ Stairs	☐ Walking	☐ Not applicable

☐ Other: _____

WH20-BB-Stapled – No Holes
4/2019

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Are you currently driving? ☐ No ☐ Yes

Has your provider given you any restrictions or special instructions? ☐ No ☐ Yes If yes, what are they?_____

☐ 24 hour supervision ☐ No Driving ☐ Change in work/school schedule

☐ Other: _____

Medical History

List medicines you are taking:

_____

Has your doctor ordered any changes in your diet? ☐ No ☐ Yes

List any supplements or herbals that you are taking.

_____

List any allergies:

_____

Have you had a CAT Scan/MRI/X-ray/other? ☐ No ☐ Yes

What were the results?

_____

Check all you use:

☐ Tobacco (# per day _____)

☐ Caffeine Coffee/ Soda (# of cups per day _____)

☐ Alcohol (# of drinks per day _____)

Lifestyle

Do you participate in any regular hobbies? ☐ No ☐ Yes

If yes, please describe: _____

_____

Prior to accident / injury, I

☐ Worked Full Time ☐ Worked Part Time ☐ Student Full Time ☐ Student Part Time

☐ Not working or attending school ☐ Other _____

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In the past month, have you used home health services? ☐ No ☐ Yes

In the past month, have you seen any other health providers? ☐ No ☐ Yes If yes, who?

_____

Do you feel safe at home? ☐ No ☐ Yes

Do you feel adequately cared for? ☐ No ☐ Yes

Patient Signature: _____ **Date**: _____

Therapist Use Only

Interdisciplinary Communication:

☐ OT: _____

☐ PT: _____

☐ SLP: _____

Reviewed by: ☐ OT Signature _____ Date: _____

☐ PT Signature _____ Date: _____

☐ SLP Signature _____ Date: _____

Copy To: ☐ OT

☐ PT

☐ SLP