



Stony Brook Medicine

HISTORY FORM: OCCUPATIONAL THERAPY

Age: _____ Male/Female _____ Hand Dominance: Right/Left/Both _____
 Highest Education Level: _____ Occupation: _____
 Current Work Status? _____

What was your work status prior to your current condition? _____

List your leisure activities/hobbies/sports _____

Do you have any difficulties with: ___ vision ___ hearing ___ speech/language? If so, please explain _____

HISTORY OF PRESENT ILLNESS

What problem(s) brings you here today? _____

When did this problem begin? _____ Did this occur gradually or suddenly? Please Describe _____

Were you hospitalized for this condition? Yes/No If yes when, for how long, & where _____

Since this problem began have your symptoms ___ improved ___ worsened ___ stayed the same

What Diagnostic tests/ procedures have you undergone for this problem (ie x-rays, MRI, EMG, surgery)? _____

Please list results/findings: _____

Have you received any other treatment for this condition (i.e. OT, PT, injections). Yes / No If yes describe type of treatment, dates received _____

What activities increase your symptoms: _____

What activities decrease your symptoms: _____

What is your pain level: Pain at Rest _____ Pain With Activity _____
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Unbearable Pain

Where is your Pain _____

Quality of Pain is: ___ sharp ___ dull ___ throbbing ___ numbness ___ tingling ___ shooting ___ burning ___ other _____

Frequency of Pain: ___ constant (76-100%) ___ frequent (51-75%) ___ occasional (26-50%) ___ rarely (25% or less)

Please list all medications you are currently taking _____

PAST MEDICAL HISTORY

Do you have/had any of the following medical conditions?

- | | |
|--|--|
| <input type="checkbox"/> Heart Condition _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Angina _____ |
| <input type="checkbox"/> Seizure Disorder _____ | <input type="checkbox"/> Vascular Disorder _____ |
| <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Diabetes _____ |

List any allergies and reactions _____

List any other medical conditions or surgeries (pregnancies, injuries, etc.) _____

Please continue on next page



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PATIENT HISTORY FORM: OCCUPATIONAL THERAPY (continued)

FUNCTION

What problems resulting from your current condition are limiting your ability to participate in your activities

Are there any techniques or assistive devices that you currently use to help you complete your daily activities? _____

Check the following activities you are having any difficulty with because of your current condition?

Check Briefly describe

<input type="checkbox"/>	DRESSING	
<input type="checkbox"/>	EATING	
<input type="checkbox"/>	GROOMING/HYGIENE	
<input type="checkbox"/>	KITCHEN ACTIVITIES	
<input type="checkbox"/>	BATHROOM ACTIVITIES	
<input type="checkbox"/>	HOUSEKEEPING	
<input type="checkbox"/>	YARDWORK	
<input type="checkbox"/>	HOMEMANAGEMENT	
<input type="checkbox"/>	MONEY/BANKING ACTIVITIES	
<input type="checkbox"/>	WRITING	
<input type="checkbox"/>	HANDLING COINS, KEYS, etc.	
<input type="checkbox"/>	TELEPHONE USE	
<input type="checkbox"/>	USE OF TOOLS	
<input type="checkbox"/>	SHOPPING	
<input type="checkbox"/>	TIME MANAGMENT	
<input type="checkbox"/>	WORK/SCHOOL TASKS	
<input type="checkbox"/>	SOCIAL ACTIVITIES	
<input type="checkbox"/>	MOBILITY	
<input type="checkbox"/>	LEISURE ACTIVITIES	
<input type="checkbox"/>	COMPUTER	
<input type="checkbox"/>	READING	
<input type="checkbox"/>	OTHER	

Do you live alone: Yes/No If no, who do you live with: _____

Do you have any assistance at home: _____

GOALS

Please list your goals/what you hope to accomplish in occupational therapy (include functional activities)

Patient Signature _____

FOR THERAPIST USE ONLY

Comments _____

Above report reviewed with patient for accuracy. **Therapist Signature** _____
