FAULKNER UNIVERSITY

CENTER FOR THERAPY AND RESEARCH

Department of Occupational Therapy
Faulkner Center for Therapy and Research
Adult Case History

Please complete the form to the best of your ability and return it prior to your evaluation appointment. We will review this form with you and help you complete it during your visit.

(Please include copies of related evaluations)

Today's Date_____

Legal Name _____ Sex____ Age_____

Birth date_____

Emergency Contact Name_____ Phone#_____

Home Address_____

Who is filling out this form? Relationship to patient_____

_____

EXPLANATION OF CONCERNS

Diagnosis:_____

Describe your concerns regarding your Gross Motor Skills (balance, coordination), Fine Motor Skills (handwriting, using tools/manipulatives), Leisure Activities, Work, or Self Care Skills (bathing, dressing, grooming, etc.) :

_____

_____

Date of Onset:_____

_____

Do you feel that you are able to participate in/successfully complete daily tasks?

(Circle One) Yes No

Describe: _____

_____

Who have you seen regarding these issues? (i.e., Doctor's, Psychologist, etc.,

Include name, address and telephone number)_____

_____

_____

Have you ever received an occupational therapy evaluation? (Circle One) Yes No

By whom?_____

When?_____

How has this issue changed since you first noticed it?_____

What has been tried to help with the issue? _____

What has helped/not helped the issue?_____

How does the issue affect you or your family?_____

_____

CONTEXTUAL INFORMATION

Language(s) spoken in the home_____

Occupation_____ Employer_____

Other occupation_____Employer_____

Level of Education:

_____

_____

Other family members present in home:

Names & Ages:

_____

_____

_____

_____

_____

Are there any family or social stressors that could be affecting you? (For example: divorce, death, military, relocation)

(Circle One) Yes No

Describe:_____

_____

_____

MEDICAL HISTORY

Please list any current medications:

_____

_____

_____

Have you ever been hospitalized? Yes No

When and why?:_____

_____

Have you ever had any serious illnesses or accidents? Yes No

Explain:_____

_____

Have you ever fainted? Yes No

If so, explain:_____

_____

Have you ever had seizures? Yes No

Describe:_____

_____

Do you have any problems with hearing? Yes No

Do you wear hearing aids? Yes No

Do you have any problems seeing? Yes No

Wear glasses? Yes No

Do you have any trouble sleeping at night? Yes No

Waking up in the morning? Yes No

Explain:_____

_____

Do you have allergies or asthma? Yes No

If so, list:_____

_____

_____

Primary doctor name, address, and telephone number:_____

Please list other professionals you see:

ENT_____

Psychologist_____

Therapist_____

Neurologist_____

Physical Therapist_____

Occupational Therapist_____

Other specialists_____

_____

Describe any other medical history: _____

_____

_____

ADL HISTORY

Skill	Yes or No
Drink from an open cup	_____
Drink from a straw	_____
Eat with fingers	_____
Eat with spoon	_____
Eat with fork	_____

Do you have feeding or swallowing problems now? Yes No

Describe:_____

_____

Are you a picky eater? Yes No

If yes, please explain_____

_____

Gross Motor Skills

Skill	Yes or No - Assist required?
Sit in chair	_____
Pull up to stand from sitting	_____
Stand stationary	_____
Walk	_____
Run	_____
Jump	_____
Bed mobility	_____

Self Care Skills

Place a checkmark by each of the following skills that you can complete independently:

__ put on socks
__ take off socks
__ put on shoes
__ take off shoes
__ untie shoes
__ tie shoes
__ put on underwear
__ take off underwear
__ put on pants
__ take off pants
__ put on shirt
__ take off shirt

__ put on jacket
__ take off jacket
__ buttons
__ zippers
__ snaps
__ bathe body
__ wash hair
__ wash face
__ brush teeth
__ brush hair
__ style hair as preferred
__ wash hands

__ cut finger/toenails
__ continence:
day: bladder __ bowel __
night: bladder __ bowel __
__ (if applicable) shaves face
__ (if applicable) shaves legs
__ (if applicable) shave armpits
__ (if applicable) manages feminine hygiene

Established hand dominance? Yes No

If yes, circle one: Left Right

Do you have any trouble with continence ? Yes No

How often?_____

_____

If you have difficulties with any of the above or any other motor activities, please explain:_____

_____

_____

_____

_____

Reading and Writing (if appropriate)

Describe any problems you have with

Reading:_____

Writing:_____

How often do you read?_____

Leisure History

Please list any leisure activities you enjoy and difficulties completing/participating in now:

_____

_____

_____

_____

_____

Do you have difficulty solving everyday problems?_____

_____

Provide an example if possible:_____

_____

Do you have difficulty following and completing multi-step directions?_____

_____

_____

_____

With occupational therapy, what is your goal/priority/desired outcome?

_____

_____

_____

_____

Provide any other information you would like for us to know:_____

_____

_____

_____

_____