



Providing services in:
 Physical Therapy
 Occupational Therapy
 Speech/Language Pathology
 Aquatic Therapy
 Special Therapy Programs

PATIENT EVALUATION FORM - ADULT

Name: _____ DOB: _____ Age: _____

Diagnoses (List all): _____

Reason for evaluation: _____

Service Requesting – Please check the type of service(s) you are requesting at Family Achievement Center?

Occupational Therapy
 Physical Therapy
 Speech Therapy

Additional concerns/Changes in condition:

Medication History:

Medications taking now	Frequency	Reason for taking medication

Past Medical History (Check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Adenoidectomy
<input type="checkbox"/> Allergies
<input type="checkbox"/> Angina
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Anemia
<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cancer/Tumor
<input type="checkbox"/> Coordination Loss
<input type="checkbox"/> COPD
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Eczema
<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Encephalitis
<input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout
<input type="checkbox"/> Headaches
<input type="checkbox"/> Head Trauma (TBI)
<input type="checkbox"/> Hearing Impairments
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hernias
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Mastoiditis
<input type="checkbox"/> Meningitis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Noise exposure
<input type="checkbox"/> Otosclerosis
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Sinusitis | <input type="checkbox"/> Skin Disease/Cancer
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Stroke/CVA
<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Visual Problems
<input type="checkbox"/> Joint/ Muscle Problems <ul style="list-style-type: none"> <input type="checkbox"/> Foot/Ankle <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist/Hand |
|--|--|--|

Hospitalizations:

Year	Operation/Illness	Hospital	Physician	City/State

Social History:

Marital Status (Circle one): Single Married Divorced Widow/Widower

Occupation: _____ Currently Employed? Yes No

Any work restrictions? Yes No What are they? _____

What type of home do you live in?

- Single family home
- Apartment
- Assisted living
- Nursing home

Do you have any of the following in your home?

- Stairs with railings How many stairs to enter the house? _____
- Stairs without railings
- Ramp
- Elevator

Do you live alone? Yes No Are you able to drive? Yes No

Do you have a regular exercise program? Yes No

If yes, what types of exercise and how frequently? _____

Therapy History:

Have you had physical, occupational or speech therapy in the past? Yes No

What type	Where	Reason	How long

What was your former therapists' conclusions or recommendations?