# OCCUPATIONAL THERAPY INTAKE

| CLIENT INFORMATION | |
|---|---|
| Name: _____<br>Address: _____<br>_____<br>Date or birth:_____<br>Age: _____<br>Occupation: _____ | Diagnosis/ What brought you in here today<br>_____<br>_____<br>_____<br>_____<br>_____ |
| How did you hear about OT services?<br>_____<br>_____<br>Do you give consent to start assessment process? Y / N<br>Medications: _____<br>_____<br>_____ | What issues are you looking to have resolved?<br>_____<br>_____<br>_____<br>How will you know that things have changed and that you have gotten better?<br>_____<br>_____<br>_____ |

## I. ENVIRONMENT

What type of dwelling do you live in? Do you have any problems moving around in your home? (apartment, 2 storey house, etc)

_____

_____

Support system Family context (married, single, children, pet, etc):

_____

How are your relationships with your family and friends?

_____

Community support (support groups, volunteer, religious groups, social meetings, etc):

_____

_____



_____ _____

Date Signature of Occupational Therapist

## II. SELF CARE AND PRODUCTIVITY

In the following chart tick the appropriate box to indicate your level of independence in doing the following activities of daily living.

Legend:
I = independent (I am able to do the activity by myself without cuing)
S=supervision (I need someone or something to remind me)
A=assistance (I mostly do the activity but someone helps me do the activity – mark who in the comments)
D=dependent (I am unable to do this for myself and require someone else to do it for me completely)
N/A= not applicable

Are you able to: I S A D N/A Comments

| ADL | I | S | A | D | N/A | Comments |
|---|---|---|---|---|---|---|
| Bathe yourself | | | | | | |
| Dress (indoor clothing) | | | | | | |
| Dress (outdoor clothing) | | | | | | |
| Use the toilet | | | | | | |
| Feed yourself | | | | | | |
| Groom (brush hair,teeth, shave) | | | | | | |
| Mobility (walk around)<br>If you use a cane or walker, then mark A | | | | | | |
| IADL | I | S | A | D | N/A | Comments |
| Meal preparation | | | | | | |
| Housecleaning | | | | | | |
| Laundry | | | | | | |
| Shopping | | | | | | |
| Medication | | | | | | |
| Budget | | | | | | |
| Telephone | | | | | | |
| Transportation (driving, public transport) | | | | | | |



_____ _____

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How do you spend a typical day from the moment you get up to the moment you go to bed?

_____

_____

_____

Describe your sleep habits (awake and bedtimes, sleep through the night, hours of sleep, ability to fall asleep, etc)

_____

_____

Any difficulties with written Communication? If yes, what are they?

_____

_____

Any difficulties with Oral Communication?

_____

_____

What are your Leisure/Hobbies?

_____

_____

_____

Career goals?

_____

## III. PERFORMANCE COMPONENTS

**Cognition**

Any problems with: (Check all that apply)

____Attention/concentration
____Organization/time management
____Frustration tolerance
____Impulsivity
____Long term memory
____Short term/working memory
____Problem solving
____Judgement
____Planning
____ Other _____



_____ _____

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Affective (Psychological and emotional)

Any feelings of depression or anxiety? If yes, describe

_____

_____

_____

Any mental health or addictions issues? If yes, describe

_____

_____

Do you drink alcohol and/or smoke marijuana? If yes how much per week?

_____

_____

What do you do to help you relax?

_____

_____

_____

Any problems with the law? If yes, describe

_____

Spiritual

What spiritual practices, activities, or beliefs give you strength?

_____

_____

_____

If you had 3 wishes, what would you change about your life?

_____

_____

_____



_____ _____

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# OCCUPATIONAL THERAPY INTAKE

## Physical

Check all that apply
Any problems with:
____Upper extremity range of motion
____Lower extremity range of motion
____Balance
____Endurance
____Strength
____Coordination
____ using your hands
Are you:
__Right Handed __Left Handed

Sensory functions – List any difficulties with:

Vision _____

Hearing _____

Touch _____

Smell _____

Taste _____

Awareness of your body in space (bumping into things) _____

Do you have any pain? If yes describe location, frequency and intensity _____

_____

Are there any other things that you would like to add?
_____
_____
_____



_____ _____
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