Initial Visit (Adult)

Patient Name:_____ **Referred by:** _____

Date of Birth: _____ **Primary Care Physician:** _____

HISTORY OF PRESENT ILLNESS

Describe your primary concerns at today's visit:

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

List your diagnosis, major illnesses and chronic conditions:

_____
_____
_____

List your previous surgeries:

List other doctors (and specialty) that have treated you:

List most recent imaging studies you have had: (x-ray, MRI, CT scan)

List medications you are currently taking:

Medication	Dose	Frequency

List any known allergies to medication, food or environment and type of reaction:

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Symptoms	Yes	No		Yes	No
Fever			Muscle/joint pain		
Sleep problems			Factures		
Vision problems			Scoliosis		
Hearing problems			Skin breakdown		
Dental problems			Headaches		
Coughing/choking with eating			Seizures		
Breathing problems			Hydrocephalus/shunt		
Abdominal pain			Depression/anxiety		
Nausea/vomiting			Attention problems		
Constipation			Irritability		
Difficulty gaining weight/Nutritional concerns			Difficulty managing cares		

***Please explain if you marked yes to any of the above symptoms;**

Family History:

Is there any family history of neurological or musculoskeletal conditions? Yes No

Functional History:

How do you eat? Orally Orally with tube-fed supplements Tube-fed

How do you get around at home and in the community?

How do you do self-care?
Feeding Independent Needs Help Dependent
Dressing Independent Needs Help Dependent
Toileting Independent Needs Help Dependent

How do you use your hands?
Right Hand Uses well As an assist No use
Left Hand Uses well As an assist No use

Do you have problems communicating? Yes No

Check any therapy you are receiving: Physical Occupational Speech Other

Social History

Are you in school? Yes No Are you working? Yes No

What is the highest level of education you have completed?

Do you smoke? Yes No

Who do you live with?