

Tara Carrington M.S. OTR/L

Intake Form

Date: _____

Name: _____

Address: _____

Phone: (H) _____ (C) _____ (W) _____

Email: _____

Age: _____ Date of Birth: _____ Marital Status: S M D W

No. and Ages of Children: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Employer: _____ Occupation: _____

Referred by: _____

_____ I understand that I am responsible for payment in full at the end of each session, and that a submittable receipt for filing an insurance claim will be provided to me upon my request.

_____ I have been advised of potential risks and side effects of myofascial release treatment and I freely and voluntarily consent to treatment.

_____ I hereby agree to hold Tara Carrington M.S. OTR/L harmless for any claims and liabilities associated with treatment.

Tara Carrington M.S. OTR/L
Occupational Therapist

Informed Consent to Occupational Therapy Treatment

I hereby consent to examination by my Occupational Therapist, which may involve removal of some clothing articles, palpation (manual examination) of body part(s) and close observation of body part(s). I consent to the use of photographs for postural comparison and educational purposes during evaluation and reevaluation.

I hereby consent to treatment by my Occupational Therapist, within her scope of practice. I understand that the treatment will be discussed with me prior to its application and that at any time I have the right to refuse treatment. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and that those risks have been explained to me and I assume those risks.

I acknowledge that my Occupational Therapist must be fully aware of my existing medical conditions. I have completed my medical history form and have disclosed to my Occupational Therapist all of the medical conditions affecting me. It is my responsibility to update my therapist on my medical history.

I have read the above noted consent. By signing this form, I consent to evaluation and treatment by my Occupational Therapist. I understand that at any time I may withdraw my consent and treatment will be stopped.

Print Name

Signature/Date

Witness

Signature/Date

Tara Carrington M.S. OTR/L, LLC

Initial Evaluation Subjective Report – Page 1

Name: _____

Date: _____

The following is very important to our evaluation process. Please fill out these forms as specifically as possible to provide us with a clear picture of your present symptoms, abilities, and goals.

What is the primary complaint that brings you here?

Please describe your symptoms as specifically as possible.

Secondary complaint?

On what date did your symptoms begin?

How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

Initial Evaluation Subjective Report – Page 2

Have you ever received other treatments for this condition? If yes, please indicate the type of treatment, length of treatment, and effectiveness.

Physical Therapy: _____

Other Treatment Services
(Chiropractor/Massages): _____

Place a vertical line on the line below to indicate the **BEST** your symptoms have been in the past week. Then place an **X** on the line below to indicate the **WORST** your symptoms have been in the past week

None _____ Worst Possible

Place a vertical line on the line below to indicate the **FREQUENCY** of your symptoms:

Never _____ Constant

What activities or positions increase your pain?

What activities or positions decrease your pain?

On the lines below, place a vertical line mark to indicate your daily

Functional ability as a percentage of normal:

On a "good day" :

0% _____ 100%

On a "bad day":

0% _____ 100%

For each activity listed below, please note the amount of time in minutes or hours that you can perform before you feel that you need to stop because of your symptoms. If you have no difficulty with the activity, mark **OK**; if you are unable to perform the activity, mark **UNABLE**; if this does not apply to you, mark **NA**.

Activity	Tolerance	Activity	Tolerance
Sitting		Computer work	
Standing		Exercise	
Walking		Writing	
Stairs (# of stairs/flights)		Shopping	
Driving		Bending	
Sleeping		Reaching (# of repetitions)	
Lifting (# of pounds)		Carrying (# of pounds)	
Other		Other	
Other		Other	

What are your goals for this treatment program? For example, what activities from the above list would you like to be able to perform better or longer? How long in minutes or hours do you need or want to perform each activity for your work or recreation?

Do you have any of the following medical conditions?

	Yes	No		Yes	No
Circulatory problems			Blackouts		
High blood pressure			Visual disturbances		
Heart trouble			Recent or rapid weight changes		
Pacemaker			Headaches		
Epilepsy			Ringling in the ears		
Diabetes			Bowel/bladder problems		
Pregnancy			Malignancy		
Stroke			Other		

Past Medical History: Please list any surgeries, traumas, accidents or other conditions and the dates of occurrence. (use the back of this sheet)

Please place a check in front of each item that you experience at least monthly.

Place an X in front of each item that you experience weekly or more frequently.

- | | |
|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Feeling inadequate/unable to cope |
| <input type="checkbox"/> Heart pounding or racing | <input type="checkbox"/> Feeling guilty or failure |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Uncontrolled crying or sadness |
| <input type="checkbox"/> Chest pain, tightness | <input type="checkbox"/> Easily annoyed or irritated |
| <input type="checkbox"/> Numbness, tingling in arm or leg | <input type="checkbox"/> Free-floating anxiety about life |
| <input type="checkbox"/> Can't keep warm enough | <input type="checkbox"/> Voice quivering, shaking |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Eyes irritated or inflamed |
| <input type="checkbox"/> Blushing, flushing face | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Eyestrain or discomfort |
| <input type="checkbox"/> Stuffy nose, congestion | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Earache or ringing noise in ears | <input type="checkbox"/> Stomach cramps |
| <input type="checkbox"/> Common colds | <input type="checkbox"/> Heartburn or indigestion |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Asthma or shortness of breath | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Hay fever or allergies | <input type="checkbox"/> Incomplete urination |
| <input type="checkbox"/> Sore, aching muscles | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Stiff or tender joints | <input type="checkbox"/> Urinary leakage |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Bowel leakage |
| <input type="checkbox"/> Trembling or twitching muscles | <input type="checkbox"/> Gas in lower bowel |
| <input type="checkbox"/> Skin rashes, eruptions | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Grinding of teeth (TMJ) | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Bowel irregularity |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Uninterested in sexual relations |
| <input type="checkbox"/> Excessive perspiration | <input type="checkbox"/> Unable to participate in sex acts |
| <input type="checkbox"/> Difficulty sleeping through the night | <input type="checkbox"/> Menstrual difficulties |
| <input type="checkbox"/> Excessive drowsiness during day | <input type="checkbox"/> Breast tenderness |
| <input type="checkbox"/> Periods of extreme fatigue | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Feeling faint or dizzy | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Feeling tense or nervous | <input type="checkbox"/> Over-eating, bingeing |
| <input type="checkbox"/> Difficulties with family or friends | <input type="checkbox"/> Lack of appetite |
| <input type="checkbox"/> Worrisome thoughts | <input type="checkbox"/> Excessive alcohol abuse |
| <input type="checkbox"/> Recurring bad thoughts | <input type="checkbox"/> Other substance abuse |
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Frequent laxative use |
| <input type="checkbox"/> Fearful of persons or places | <input type="checkbox"/> Other: |

Please shade areas of pain and/or symptoms.