MIDWESTERN UNIVERSITY

Therapy institute
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Therapy Institute Adult Case History

Client's Name:	Date of Birth:
Medical Diagnosis (if applicable):	Allergies:

Physician Information	
Primary Care Physician:	Practice Name:
Referring Provider (if different than above):	

Medications

(Please list all medications you are currently taking, attach separately if needed)

In the past 30 days, have you received home health services?	☐Yes ☐ No
Have you had any other recent illnesses, accidents, or hospitalizations? ☐Yes ☐ No If yes, please describe (attach separately if needed):	

Past Medical History (please indicate if you have experienced any of the following)

○ Stroke	○ Heart Problems	○ Vision Problems (not corrected)
○ Paralysis	○ Cancer	○ Muscular Weakness
○ Head Injury	○ Meningitis	○ Muscular Tremors
○ Seizures	○ Diabetes	○ Headaches
○ Parkinson's Disease	○ Vocal Changes/Injury	○ Blood clots
○ Memory Impairment	○ Swallowing Difficulties	○ Asthma
○ Depression	○ Mumps	○ Ulcers
○ Dizziness	○ Measles	○ Pacemaker
○ Ears Ringing	○ Kidney Disease	○ High Blood Pressure
○ Earaches	○ COPD or other respiratory disorders	○ Fibromyalgia
○ Ear Drainage	○ Osteoporosis	○ Liver Disease
○ Osteoarthritis	○ Macular Degeneration	○ Glaucoma
○ Rheumatoid Arthritis		

For any condition(s) checked above, please describe briefly (attach separately if needed):

Outpatient Therapy History:	**Previous (Dates)**	**Current (Dates)**
Occupational Therapy		
Physical Therapy		
Speech-Language Therapy		
Vision Therapy/Visual Rehab		
ABA (Applied Behavior Analysis)		
Psychology/Behavioral Health		
Other:		

Mobility

Do you use an assistive device in the home? Do you use an assistive device in the community? If so, which one?

☐ walk independently ☐ walk with assistance ☐ cane ☐ walker ☐ scooter ☐ manual wheelchair ☐ motorized wheelchair ☐ other

Please describe any special concerns about your mobility:

Current Health (please indicate if you are currently experiencing any of the following)

○ Fever/Chills/Sweats	○ Vision Changes	○ Numbness or tingling
○ Difficulty Speaking	○ Shortness of breath	○ Difficulty swallowing
○ Nausea/Vomiting	○ Poor balance/falls	○ Increased pain at night/rest
○ Unexplained Weight Loss	○ Changes in appetite	○ Change in (Bowel) or (Bladder) control, habits, or appearance
○ Dizziness	○ Pain with meals	○ Blurred Vision
○ Chest Pain	○ Unusual pain with menstruation	○ Double Vision
○ Uncontrollable sadness		
○ Feelings of helplessness		

Are you currently receiving care for any of these symptoms? ☐ Yes ☐ No

If yes, please describe:

Hearing

Do you feel that you have a hearing problem? ☐ Yes ☐ No

If yes, please describe:

Have you ever had your hearing tested? ☐ Yes ☐ No Date of last exam:_____

What were the results? ☐ Normal ☐ Hearing loss noted in ☐ left ear ☐ right ear

inconclusive

Do you use a hearing device? ☐ Yes ☐ No

Please identify up to three important activities that you are unable to do or have difficulty with as a result of your current problem/diagnosis and rate them using the scale.

1. Activity:
0 1 2 3 4 5 6 7 8 9 10 **No Issues** **Cannot Perform**
2. Activity:
0 1 2 3 4 5 6 7 8 9 10 **No Issues** **Cannot Perform**
3. Activity:
0 1 2 3 4 5 6 7 8 9 10 **No Issues** **Cannot Perform**

Concerns: Please check the bubbles below that describe the concerns you have

Occupational Therapy

- o Sensory sensitivity (bright lights, loud noises, difficulty in overcrowded areas)
- o Social anxiety
- o Handwriting/changes in coordination
- o Self-care skills (buttons, zippers, dressing and undressing)
- o Difficulty completing housework
- o Difficulty bathing/showering
- o Feelings of clumsiness/dropping items
- o Difficulty using utensils
- o Upper extremity weakness
- o Navigating outings in the community
- o Other: (please describe)

Speech and Language

- o Articulation, accent, or verbal speech issues
- o Difficulty understanding language
- o Difficulty finding words to say in general conversations
- o Difficulty putting ideas into words/sentences
- o Memory, following directions, retaining information
- o Need for a system to help speak (communication book, technology, etc.)
- o Stuttering, rate of speech
- o Feeding or swallowing difficulties
- o Voice, resonance, loudness issues
- o Other: (please describe)

Vision

- o Blurry vision for near tasks
- o Blurry vision for distance tasks
- o Headaches with near work
- o Burning, itchy, or watery eyes
- o Skipping/repeating lines while reading
- o Spatial disorientation in busy environments – e.g. trouble with focusing in the grocery stores
- o Objects appear to move while reading
- o Poor concentration on tasks
- o Double vision
- o Tilting head or closing one eye when reading
- o Photosensitivity/glare at computer
- o Photosensitivity/glare inside
- o Photosensitivity/glare outside
- o Omitting small words when reading
- o Poor reading comprehension

Physical Therapy

- o Balance
- o Flexibility
- o Posture
- o Reduced strength
- o Joint mobility/pain
- o Coordination
- o Chronic pain
- o Sciatica
- o Scoliosis
- o Arthritis
- o Abnormal movement patterns

Psychology

- o Anxiety
- o Depression
- o Stress
- o Substance Use
- o Eating Disorders
- o Anger
- o Sadness
- o Worry
- o Isolation
- o Loneliness
- o Hopelessness
- o Grief
- o Insomnia or difficulty sleeping
- o Changes in mood

If you filled in any of the bubbles above, please fill out the addendums (pages 5-9) that correspond to the columns you identified concerns with.

Physical Therapy Addendum

Do you feel unsteady when walking or standing?	☐ Yes	☐ No
Are you worried about falling?	☐ Yes	☐ No
Have you fallen in the last year?	☐ Yes	☐ No

Are you currently experiencing any pain/symptoms in your body that may impact your ability to perform exercises today? ☐ Yes ☐ No If yes, please describe:

Where is your PRIMARY symptom located? _____

Approximately when did this symptom begin? _____

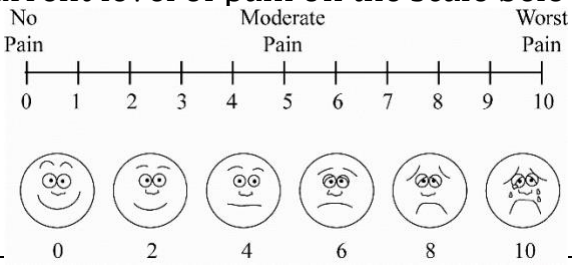
How did your symptoms start (injury, gradual, sudden)? _____

Have you ever had this problem before? ☐ Yes ☐ No If yes, please answer the next 2 questions:

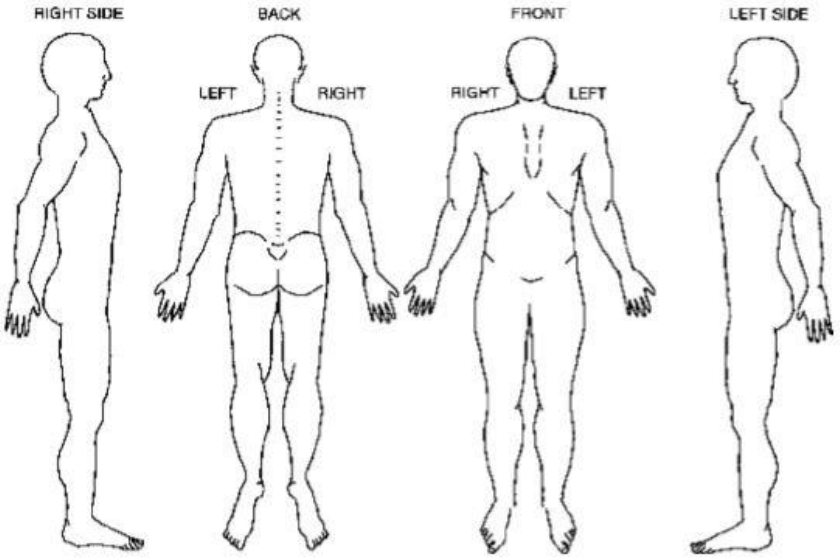
What treatments helped? _____

What treatments failed? _____

Please identify your current level of pain on the scale below:



Please indicate the location of any and all current pain and/or irritation on the body diagrams:



Occupational Therapy Addendum

List Your Skill Level and any additional comments necessary for the evaluator:

- (D) Dependent: caregiver performs the skill
- (Max) Maximal Assistance: mostly caregiver, but patient attempts to help
- (Mod) Moderate Assistance: patient is performing 50% of the skill
- (Min) Minimal Assistance: patient is mostly performing the skill, a little help from caregiver
- (I) Independent: patient completes independently

Activities of Daily Life	Level of Assistance					Comments
Dressing/Undressing (shirts, jackets, pants, socks, shoes)	D	Max	Mod	Min	I	
Toileting	D	Max	Mod	Min	I	
Bathing/Showering	D	Max	Mod	Min	I	
Grooming (hair brushing, styling, teeth brushing, wiping face, etc.)	D	Max	Mod	Min	I	
Completing self-care routines (morning routine, evening routine)	D	Max	Mod	Min	I	
Transferring from bed to chair, or in and out of the car, in and out of shower	D	Max	Mod	Min	I	
Managing Medications	D	Max	Mod	Min	I	
Cooking meals (navigating the kitchen safely)	D	Max	Mod	Min	I	
Doing Housework	D	Max	Mod	Min	I	
Shopping	D	Max	Mod	Min	I	
Using the phone	D	Max	Mod	Min	I	
Managing Finances	D	Max	Mod	Min	I	

Additional Comments or Concerns:

Psychology Addendum

In the past few weeks, how often have you been bothered by the following problems?

	Not at all	**Several Days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Thoughts that you would be better off dead, or of hurting yourself				
Feeling anxious or worried				
Feeling stressed				

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Are you currently receiving care for any of these symptoms? ☐ Yes ☐ No

If yes, please describe.

Have you been hospitalized in the past 3 months for mental health concerns?

☐ Yes ☐ No

If yes, please describe.

Speech Addendum

What language is used most often at home?

At work?

Are there any other languages spoken in the home? ☐ Yes ☐ No

If yes, explain:

Do you feel that you have a speech-language problem? ☐Yes ☐No

Have you ever had a speech-language evaluation/screening? ☐Yes ☐ No

If yes, when and where?

What were the results?

Have you ever been enrolled in speech-language services, or are you participating in speech therapy currently? ☐ Yes ☐ No

If so, where and for how long?

Please describe services and progress:

How do you communicate wants or needs?

What do you do when you need help with something?

Vision Addendum

Ocular History	
Date of Last Vision Exam:	Doctors Office:
Visual Conditions:	
Do you wear: Glasses? ☐ Yes ☐ No If yes, for distance, reading, or full-time? _____ Contact Lenses? ☐ Yes ☐ No Filters/sunglasses for computer/inside use? ☐ Yes ☐ No Filters/sunglasses for outside use? ☐ Yes ☐ No Low Vision devices? ☐ Yes ☐ No If so, what kind of low vision devices and where did you get them from?	
Do you feel that you have a vision problem? ☐ Yes ☐ No If yes, please describe:	
Have you ever had vision surgery? ☐ Yes ☐ No Have you had ocular injections or you currently receiving them? ☐ Yes ☐ No If so, where and when? Reason? Results:	