

Midwestern University – Therapy Institute

Adult Case History

Client Information

Date Completed:

Client's Name:

Date of Birth:

Medical Diagnosis (if applicable):

Birth Sex: • Male • Female

Gender Identity:

- Male
- Female
- Non-Binary
- Prefer to Self-Describe

Allergies:

Primary Language:

Address:

City/State/Zip:

Please check the box next to the best number to reach you during the day:

- Home Phone:
- Cell Phone:
- Work Phone:

Email Address:

Present Occupation:

Past Occupation (if applicable):

Physician Information

Physician Name:

Practice Name:

Address:

City/State/Zip:

Office Phone:

Office Fax:

Referring Provider (if different than above):

Medications

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

Past Medical History

Please indicate if you have experienced any of the following:

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

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

Outpatient Therapy History

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

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):

Mobility

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

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

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
- Hearing loss noted in 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. Rate them using the following scale: 0 (No Issues) to 10 (Cannot Perform)

1. Activity & Rating:

2. Activity & Rating:

3. Activity & Rating:

Concerns

Please check the box(es) below that describe the concerns you have.

Occupational Therapy

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

Speech and Language

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

Vision

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

Physical Therapy

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

Psychology

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

If you checked any of the boxes above, please fill out the addendums below that correspond to the sections you identified concerns with.

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?

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, etc.)	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:

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 are you currently receiving them? • Yes • No

If so, where and when?

Reason?

Psychology Addendum

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

Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed, or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

Thoughts that you would be better off dead, or of hurting yourself

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling anxious or worried

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling stressed

- Not at all
- Several days
- More than half the days
- Nearly every day

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?

- 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:

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 using the following scale - 0 (No Pain) to 10 (Worst Pain):

Please indicate the location of any and all current pain and/or irritation on the body diagrams below, or use the accompanying text field to provide a detailed description.

