



Journeys
Occupational Therapy LLC

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ADULT HEALTH HISTORY AND INFORMATION FORM

Name _____ Birth Date _____ Today's Date _____

Address _____ City/State _____ Zip _____

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

Email: _____ Occupation _____

Referral Source _____ May I thank them for referring you? Yes No

Have you received OT/Craniosacral therapy before? Y N

Primary reason for appointment? _____

List areas of complaint, pain, or tension: _____

_____ How are these concerns affecting your function in life?

Work: _____

Leisure/Play: _____

Sleep/Self-Care/Appetite: _____

Do you have a medical diagnosis: _____

Are you now under medical/therapeutic treatment for this or other conditions? Yes No

If so, what treatments? _____

Physician or Practitioners name _____ Tel #: _____

Are you seeking Craniosacral treatments to assist with this condition? Yes No

Please list any precautions the therapist should be aware of: _____

Please list any medication/s you are taking (including over-the-counter)

_____ Please (date/describe) any hospitalizations or surgeries:

_____ Any significant injuries (accidents, fractures, etc./when, what, and treatments):

OVER----->

Circle any of the following which currently apply to you; mark any that occurred in the past with a "P".

Allergies	Arthritis	Depression	Sinusitis
Cancer	Anxiety/Panic	Diabetes	Hip replacement
Blood clot	Spinal problems	Insomnia	High/Low blood pressure
Joint disease	Numbness	Scoliosis	Fatigue
Respiratory/lung	Sciatica	Fractures	Chronic Pain
Headache/Migraine	Fibrotic cysts	Pregnancy	Poor Circulation
Fibromyalgia	Asthma	Heart condition	Sleep disorder
Obsessive-Compulsive	Bipolar Disorder	Pacemaker	Diarrhea
Bronchitis	Pneumonia	Constipation	Male Issues
Seizures	TMJ	Female Issues	

Any other pertinent medical information:

Any known contraindication to slight elevations in intracranial pressure? _____

CONSENT FOR CARE

You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist for information about their training and credentials.

I, _____, understand that Occupational Therapy is not a substitute for standard medical care, and I have indicated all of my known medical conditions. I will alert the practitioner to any changes in my health status, including medication changes. It is my choice to receive Occupational Therapy with an understanding of the risks and benefits, and I give my consent for treatment. I understand that there is no stated guarantee for effectiveness of treatment.

Signature _____ Date _____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Fee is \$80 per hour, or \$22.50 per 15 minute unit for partial hour. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. We can submit to your insurance company as an out-of-network provider, although payment remains due at time of service (your insurance company will reimburse you directly for any covered service).

Please initial here _____ if you would like to receive itemized invoices at the end of the month to submit directly to your insurance yourself. These are typically mailed the first week of the month after your appointment.

Please circle one: I would/would not like a monthly statement mailed to my home for my records.