Journeys
Occupational Therapy

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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
Joint disease	Numbness	Scoliosis	pressure
Respiratory/lung	Sciatica	Fractures	Fatigue
Headache/Migraine	Fibrotic cysts	Pregnancy	Chronic Pain
Fibromyalgia	Asthma	Heart condition	Poor Circulation
Obsessive-Compulsive	Bipolar Disorder	Pacemaker	Sleep disorder
Bronchitis	Pneumonia	Constipation	Diarrhea
Seizures	TMJ	Female Issues	Male Issues

Have you had surgery to correct strabismus or eye movement difficulties? Yes No

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 any service provided at Journeys Occupational Therapy, LLC, 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 Craniosacral Therapy, Massage Therapy, or 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. Sessions are 50-55 minutes in length, although extended sessions are available at client request if scheduling allows. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness and weather-related events); cancellations within 24 hours will be subject to a $50 cancellation fee at therapists' discretion.

As a wellness service, Craniosacral Therapy and/or Massage Therapy are not covered by most health insurance policies. Occupational Therapy for diagnosed medical conditions with a doctor's referral may be a covered service. It is impossible for us to know what your policy does and does not cover, as they vary dramatically. Please check directly with your insurance company if you have any questions.

Please initial understanding of payment policy: _____