Alyssa Frey, M.S., OTR/L, LLC
11 Broadview Ave. Maplewood, NJ 07040
alyssafreycst@gmail.com

ADULT INTAKE FORM (age 13+)

General Information

Name: ____

Age: _______________________________________

Address: _______________________________________

Phone number: ______________________________________

Email: ____

Medical History

Childhood Illnesses:

____

____

Medical History:

____

____

Past accidents/surgeries/traumas (emotional and physical):

____

____

Current stressors:

____

____

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In case of emergency call: ____

Physician: ____

Referred by: ____

Other therapies (traditional and non-traditional)

____

____

Medications, Vitamins, Supplements

____

____

Exercise & Nutrition:

____

____

Personal goals for therapy:

____

____

____

(Signature of client – *To sign, enter first and last name*)

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DISCLOSURES TO INDIVIDUALS AND HIPAA PRIVACY AUTHORIZATION FORM

There may be times when it is necessary for an individual involved in your care to call me to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Alyssa Frey, M.S., OTR/L, LLC to use and disclose health information related to my current treatment to: *Please indicate name, relationship, and other relevant information.*

1.____

2. ____

3. ____

4. ____

5. ____

This authorization for release of information covers all past, present, and future periods.

☐ **I authorize the release of my complete health record.**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: ____________________________________

Date: ____