



# Hands On Therapy

Jean A. Croll, M. Ed, OTR/L  
Occupational Therapist

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## INITIAL EVALUATION SUBJECTIVE REPORT

DATE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ MEDICAL DIAGNOSES \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOW DID YOU HEAR ABOUT ME? \_\_\_\_\_

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*THE FOLLOWING IS VERY IMPORTANT IN THE EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE ME WITH A CLEAR PICTURE OF YOUR PRESENT PAIN AND FUNCTIONAL STATUS.*

1. Describe your symptom(s):

What is your primary complaint that brings you to MFR? \_\_\_\_\_

Secondary complaint? \_\_\_\_\_

2. Have you ever received the following treatment for this condition?

<i>Treatment</i>	<i>yes</i>	<i>no</i>	<i>How long?</i>	<i>Helpful?</i>
Occupational Therapy				
Physical Therapy				
Chiropractic				
Other (specify)				

3. Do you have any of the following medical conditions?

Circulatory problems	Visual disturbances	Diabetes
High blood pressure	Weight change ( >15 lbs)	Pregnancy
Heart trouble	Headaches	Blackouts
Pacemaker	Ringling in ears	Malignancy
Epilepsy	Bowel or bladder problems	Stroke

4. Please place a check in front of each item that you experience at least monthly.

Headaches	Difficulty falling asleep	Heartburn, indigestion
Heart pounding or racing	Difficulty sleeping through night	Nausea or vomiting
Irregular heartbeat	Awaken too early in morning	Frequent urination
Chest pain, tightness	Excessive daytime drowsiness	Incomplete urination
Cold hands or feet	Periods of extreme fatigue	Painful urination
Numbness/tingling in arm/leg	Feeling faint or dizzy	Urinary leakage
Can't keep warm enough	Feeling tense or nervous	Bowel leakage
Sweaty palms	Difficulties w/ family or friends	Gas in lower bowel
Blushing, flushing of face	Difficulties with co-workers	Diarrhea
Coughing	Worrisome thoughts	Constipation
Stuffy nose, congestion	Recurring bad thoughts	Bowel irregularity or frequency
Earache/ringing noise in ears	Thoughts of suicide	Uninterested in sexual relations
Common colds	Fearful of persons or places	Unable to enjoy sexual activity
Sore throat	Feel inadequate, unable to cope	Unable to participate in sex act
Asthma or shortness of breath	Feeling guilty or a failure	Menstrual difficulties
Hay fever or allergies	Uncontrolled crying or sadness	Pre-menstrual syndrome
Sore, aching muscles	Easily annoyed or irritated	Breast tenderness
Stiff or tender joints	Free-floating anxiety about life	Hot flashes
Back problems	Voice quavering, shaking	Water retention
Trembling or twitching muscles	Eyes irritated or inflamed	Overeating, bingeing
Skin rashes, eruptions	Vision blurred	Lack of appetite
Grinding of teeth (TMJ)	Eyestrain or discomfort	Excessive alcohol usage
Dry mouth	Nosebleeds	Smoking
Mouth sores	Stomach cramps	Other substance abuse
Excessive perspiration	Intestinal cramps	Frequent laxative usage

5. List past medical history/dates of occurrence. (Include surgeries, accidents and other traumas.)

6. Please list all medications which you are currently taking:

<i>Medication</i>	<i>For treatment of</i>	<i>Dosage</i>	<i>Effectiveness</i>

7. When did your symptom(s) begin? \_\_\_\_\_

8. How did your symptom(s) begin? \_\_\_\_\_

9. Rate the INTENSITY of your pain (indicate with a slash mark below).

\_\_\_\_\_

*no pain. . . . . worst pain imaginable*

10. Rate the FREQUENCY of your pain (indicate with a slash mark below)..

\_\_\_\_\_

*never. . . . . constant*

11. Rate your pain (indicate with a slash mark below):

*no pain. . . . . worst pain*

At its worst \_\_\_\_\_

Most of the time \_\_\_\_\_

At its best \_\_\_\_\_

Night (sleeping) \_\_\_\_\_

12. At what time of day are your symptoms the worst?

At what time of day are your symptoms the best?

13. SLEEP BEHAVIOR:

Do you have trouble falling asleep? \_\_\_\_\_

How many times do you wake in the night? \_\_\_\_\_

Is your sleep restful? \_\_\_\_\_

How long before you fall back to sleep?

14. What activities INCREASE your pain? \_\_\_\_\_

What activities DECREASE your pain? \_\_\_\_\_

15. . Estimate the average amount of time you spend in each of the following activities per day:

\_\_\_\_\_ SLEEPING

\_\_\_\_\_ LEISURE

\_\_\_\_\_ OTHER

\_\_\_\_\_ WORKING

\_\_\_\_\_ HOUSEHOLD

15. How much total time do you tolerate being in a **vertical** position per day? \_\_\_\_\_  
(e.g. sitting, standing, walking, driving)

How much total time do you spend in a **horizontal** position per day? \_\_\_\_\_  
(e.g. reclining, lying down, sleeping)

17. Place slash marks on the line scales below to indicate your level of daily functional ability overall.

	<i>inactive. . .</i>	<i>. . . normal</i>
On a good day	0 % _____	100%
On a bad day	0 % _____	100%

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P. O. Box 87 Norfolk, MA 02056

Phone (508) 560-4007 ♦ Fax (508) 520-4895

Jean@Hands-On-Therapy.net

18. Rate your difficulty with the following tasks and activities:

<i>No difficulty</i>	<i>Minimal difficulty</i>	<i>Mod. Difficulty</i>	<i>Maximal Difficulty</i>	<i>Unable to do</i>	
					Grooming
					Oral Hygiene
					Bathing/Showering
					Toilet Hygiene
					Dressing
					Feeding and Eating
					Medication Routine
					Health Maintenance
					Socialization
					Functional Communication
					Functional Mobility
					Community Mobility
					Emergency Response
					Sexual Expression
					Home Management
					Clothing Care
					Cleaning
					Meal Preparation/Cleanup
					Shopping
					Money Management
					Household Maintenance
					Safety Procedures
					Care of Others
					Play/Leisure Exploration
					Play/Leisure Performance
					Vocational Activities (specify)

19. CLIENT GOALS: List what you would like to be able to do as a result of therapy.

<i>ACTIVITY</i>	<i>DURATION/ HOW OFTEN</i>	<i>BY WHEN</i>

**PLEASE READ FULLY BEFORE SIGNING.**

I understand that the myofascial release techniques I receive are part of a comprehensive occupational therapy treatment plan, based on a physical evaluation and client-reported information of pain and functional limitations. Because certain bodywork techniques are contraindicated under certain medical conditions, I affirm that I have disclosed all my known medical conditions and concerns and have answered all question completely and honestly. I agree to keep my therapist updated on any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so. If I experience pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. I understand that I have the right to terminate any treatment technique immediately and at any time by simply telling the therapist to stop.

I also understand that any inappropriate or sexually suggestive remarks or misconduct by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

**CANCELLATION POLICY** I agree to notify my therapist within 24 Hours of any cancellation, or I may be liable for full payment of scheduled appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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