Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Phone: _____ E-mail: _____

Emergency Contact: _____

Employer: _____

Occupation: _____

Leisure Interests: _____

Referred By: _____

Primary Complaint:

Symptoms:

Onset Date of Symptoms:

Are your symptoms a result of an accident or trauma?

How did your symptoms begin?

Have you ever received treatments for this condition? If yes, please indicate which type of treatment, length of treatment, and effectiveness.

Please place a vertical line below to indicate your pain level today:

None_____worst possible

Please rate your pain today 0-10 (zero being no pain and 10 being the worst pain possible:

What is the lowest pain level you have experienced 0-10?

What is the worst pain level you have experienced 0-10?

Please indicate how frequent your symptoms effect you:

_____ Daily and constantly

_____ Daily but not constantly

_____ Less often than daily

_____ Rarely

_____ I do not have any pain

What activities or positions increase your pain?

What activities, positions, or modalities (heat, ice) decrease your pain?

How does your pain effect your daily functioning?

What is your goal for treatment?

List of Current Medications:

Please mark each symptom you have experienced recently:

___ Headache	___ Migraines
___ Heart pounding or racing	___ Sinus Troubles
___ Irregular Heartbeat	___ Pain in cheeks
___ Chest pain, tightness	___ Buzzing in Ear
___ Numbness or tingling	___ Ear Pain
___ Coughing	___ Hearing Loss
___ Sore Throat	___ Tooth Pain
___ Back Problems	___ Blurred Vision
___ Stiff or Tender Joints	___ Nausea/Vomiting
___ Grinding of Teeth	___ Painful urination
___ Jaw Pain	___Bowel Leakage
___ Feeling of Faint	___Workplace Injury
___ Dizziness	___ Car Accident
___ Frequent Urination	___ Sports Injury
___ Urinary Leakage	___ Surgery of Any Type

Other Pertinent Information or Symptoms you have experienced recently:

Informed Consent to Occupational Therapy Treatment

I hereby consent to examination by Hillary Kibgis, MOT, OTR/L, which may involve removal of some clothing articles, palpation (manual examination) of body part(s), and close observation of body part(s). I consent to possible use of photographs for postural comparison and educational purposes during evaluation and treatment.

I hereby consent to treatment by Hillary Kibgis, MOT, OTR/L within her scope of practice. I understand that the treatment will be discussed with me prior to its application and that at any time I have the right to refuse treatment. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks, that these risks have been explained to me, and that I assume those risks.

I acknowledge that Hillary Kibgis, MOT, OTR/L must be fully aware of my existing medical conditions. I have completed my medical history form and have disclosed to Hillary Kibgis, MOT, OTR/L all of my medical conditions effecting me. It is my responsibility to update my therapist on my medical history.

I have read the above noted consent. By signing this form, I consent to evaluation and treatment by Hillary Kibgis, MOT, OTR/L. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand that effects of treatment may result in increased pain and soreness, skin redness, joint stiffness, skin irritation, and overall discomfort. I have been advised of potential risks and side effects of treatment and I freely and voluntarily consent to treatment. I hereby agree to hold Function Therapeutics, LLC and Hillary Kibgis, MOT, OTR/L harmless for any claims and liabilities associated with treatment.

Client Signature: _____

Date: _____