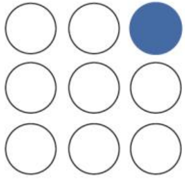

To Schedule:
Ph: (248) 893-6192
Fax: (248) 457-5490
info@therapyspotmi.com

30903 W. 10 Mile Rd Suite B
Farmington Hills MI 48336

675 E. Big Beaver Rd. Suite 201
Troy, MI 48083

www.therapyspotmi.com

Date: ______________

New Patient Intake Form- Adult

Please Circle Your Preferred Location

675 E. Big Beaver Rd Suite 201
Troy, MI 48083

30903 W. 10 Mile Rd. Suite B
Farmington Hills, MI 48336

Patient Information

Patient Name: __________________________________ DOB: ____________ Age: ________ Gender: _________
Name of Person Completing Form (if different from patient): _________________________________
Relationship to Patient (if different from patient): ____________ Language spoken: __________________________
How did you hear about the Therapy SPOT? ____

Contact Information

Mailing Address: _________________________________ City/State: _______________________ Zip Code: _______
Home Phone #_____________________ Cell Phone # ______________________ Work Phone # ________________
Best Times to Call: (home) ___________________ (cell) ______________________ (work) ______________________
Email address: ___________________________________ Preferred Method of Communication: Home Cell Work
Emergency Contact (name and relationship if applicable): ___________________________ Ph # ________________

Insurance

Name of Person Insured: ___________________________ Relationship to Patient: _____________ Birthdate: __________
SS# _____________________ Occupation: __________________________ Employer: ___________________________
Employer Address/Phone # ____
Primary Insurance: ___________________________ Group Number: _______________ Contract #: ___________
Secondary Insurance: __________________________ Group Number: ______________Contract #: ______________

Health and Medical History

Please list any known allergies: ____
Please list any known or suspected diagnoses or medical precautions:____
Primary Concern/reason for today's visit: ____
Please list any medications/vitamins and quantity: ____
____
Are you currently on a special diet or have any food restrictions? Yes No ____________________________________
Do you wear prescription glasses or contact lenses? Yes No ____

Patient Name: ___________________________

Tests/Procedures/Surgeries (list additional on back of page):

Test/Procedure	Reason	Date	Results
Vision			
Hearing			

Were any gross motor or speech milestones not achieved or achieved late? If so, please describe:

____

____

Name of Referring Physician: ______________________________ Phone # ___________________

Other Physicians and Specialists (i.e.: physician, neurologist, psychologist):

Type	Name	Reason

Past/Current Therapy Services

Type	Frequency	Location	Dates	Current?
EX: psychology	1x/week		1/2012-1/2013	Y N
				Y N
				Y N
				Y N
				Y N

School/Education/Work

Are you currently in school or another educational program? Yes No

If yes, Name of School: ____ Grade/Level: ___________

Do you receive or require any accommodations to be successful in school (if yes, please list): Yes No

Please list/explain any concerns or difficulties:

____

____

If you are not currently in school, did you have any challenges or require any accommodations in the past to be successful? If yes, please explain:

____

____

What is the highest level of education you have completed? ________________________________

Currently employed? Yes No Role/position/title: ______________________________________

Full or part time? ______________ Please describe any challenges or require any accommodations in the workplace:

____

Patient Name: ___________________________

Participation in Routines

Are there any tasks in your daily routine that are difficult or you require assistance with? Yes No
If yes, please explain:
____
____
____
____
Would you describe yourself as clumsy or uncoordinated? If yes, please explain: ______________________________
____
Do you have difficulty concentrating, paying attention, or sitting still? If yes, please explain: ____________________
____

Speech & Feeding

Current speech concerns: ____
How do you communicate (check all that apply)?

Body language/facial expressions ☐ Single words ☐ Sentences longer than 4 words ☐ Non-verbal
☐ Eye gaze ☐ Sign Language ☐ Gesturing/pointing ☐ Sounds (vowels, grunts)

Does you use an Augmentative Communication Device? If yes, please list: ______________________________
Do you have difficulty with:

Remembering verbal directions/information?	Yes	No
Following directions?	Yes	No
Respond correctly to who/what/where/when/why questions?	Yes	No
Describing events or thoughts?	Yes	No

How much of your speech do others understand? 0% 25% 50% 75% 100%
Do you consider yourself a picky eater? Yes No
If yes, please describe the tastes/textures/foods that you do not eat:
____
____

Sensory Processing

Check all that apply:	YES	PAST
Have unusual eating habits (limited foods, overeating, strong preferences)	_____	______
Have unusual sleeping habits/schedule (difficulty falling asleep, staying asleep, etc)	_____	______
Easily engrossed in activity (tunes out sights/sounds around you)	_____	______
Very high or low energy level	_____	______
Have great difficulty with transitions or changes (from task to task, indoor to outdoor, or major life events)	_____	______
Resistant to change in daily routines or schedules	_____	______
Use of substances- alcohol, drugs, etc.	_____	______
Drink excessive amounts of caffeine	_____	______

Check all that apply:	YES	PAST
Bothered by clothes (materials, tags, seams, tight or stiff clothing, etc.)	_____	_______
Excessively ticklish or bothered by ‘light touch’	_____	_______
Frequent fidget with objects, bite nails, or play with hair	_____	_______
Dislike the feeling of showers, being splashed, or sand at the beach	_____	_______
Frequently washing hands/dislike getting hands messy	_____	_______
Bothered by socks/shoes or hates being barefoot	_____	_______
Avoid amusement rides or often gets car/motion sickness	_____	_______
Thrill seeker- likes to go fast, amusement rides, takes risks	_____	_______
Difficulty sitting still (rocks, shakes leg, tips chair, sways)	_____	_______
Frequently bites or chews nails, lips/cheeks, pens or other objects	_____	_______
Sensitive to smells, scented lotions, perfumes	_____	_______
Avoids crowds, busy environments or places	_____	_______
Sensitive to loud sounds, easily distracted by sounds/noise	_____	_______
Need background noise/music to focus on tasks	_____	_______
Tendency to be very loud, hyper or overly active	_____	_______
Notice sounds that others do not seem to hear (clock, refrigerator, etc)	_____	_______
Strong need for physical activity/intensity	_____	_______
Tendency to be rougher than you intend to or seem to have a need for hugs/squeezes/cuddling	_____	_______
Particular about light when sleeping (can’t sleep if room isn’t dark or need light in room to sleep)	_____	_______
Difficulty noticing when hands/face are dirty	_____	_______
Difficulty finding objects in purse or pocket without looking	_____	_______
Difficulty locating items in a messy junk drawer (ex: seem to overlook items in plain sight)	_____	_______
Easily disoriented or lost in stores or when driving	_____	_______
Difficulty judging distance between cars, when stepping up curbs (ex: trips often)	_____	_______
Bumps into objects frequently or seems more clumsy than others	_____	_______
Difficulty reading/understanding a map, bus route, etc.	_____	_______
Poor time management or ‘sense’ of time	_____	_______
Difficulty completing simple math in your head, or turning images in your head (ex: imagining how a room would look with the furniture set up differently- have to actually see it)	_____	_______
Difficulty learning new motor skills or walking on uneven surfaces	_____	_______
Confuse left vs right	_____	_______
Easily loses balance or drops items	_____	_______
Easily fatigued by physical tasks or strong preference for sedentary tasks	_____	_______
Difficulty starting or finishing tasks	_____	_______
Described as stubborn, impulsive, controlling, overly sensitive, or indecisive	_____	_______
Easily frustrated, anxious, or has many fears/phobias	_____	_______
Prefers being alone over group tasks or has difficulty socializing with/relating to others	_____	_______

Goals for Therapy

Please list at least 3 goals you hope to achieve with the help of therapy:

1. ____
   ____
2. ____
   ____
3. ____
   ____