Allied Rehab
Speech, Occupational & Physical Therapy

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ADULT THERAPY HISTORY FORM

Name ______________________________________Date of birth __________________

Person filling out this form ☐ Self ☐ Other ________________________________

What is your primary language? __________________________

What other languages do you speak? _______________________

PLEASE FILL OUT THE SECTION THAT IS RELEVANT TO YOUR VISIT TODAY

SPEECH-LANGUAGE

Symptom	Yes	Sometimes	No
Difficulty swallowing			
Difficulty expressing thoughts			
Difficulty being understood by others			
Difficulty understanding what others are saying to you			
Orientation/memory			
Focusing/attention			
Reading/writing			
Finding words			
Fluent speech (stuttering)			
Oral motor weakness (weakness, difficulty coordinating tongue, cheeks, lips, etc.)			

Other: ____

OCCUPATIONAL THERAPY

Symptom	Yes	Sometimes	No
Difficulty completing self-care tasks (showering, toileting)			
Tingling/ Numbness in Arm			
Hand Injury? If so, where? _________________			
Pain? If so, where? ________________________			

Did you have surgery? If so, where/when? _______________________________

PHYSICAL THERAPY

Symptom	Yes	Sometimes	No
Difficulty with balance			
Difficulty walking			
Falls			
Pain If so, where? __________________________			
Weakness If so, where? __________________________			
Difficulty with getting out of bed			
Numbness/ Tingling If so, where? _________________			
Do you use any mobility/ assistive equipment, ie, walker, cane, braces			

Did you have surgery? If so, where/when? ____________________________________