Advanced Therapy Solutions

ADULT CLIENT HISTORY QUESTIONNAIRE

Date: _____

GENERAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Best way to reach you: (Daytime) _____ (Evening) _____

Place of Employment: _____

Employment Address: _____

_____Work Phone:_____

Spouse Place of Employment: _____

Employment Address: _____

_____ Work Phone: _____

Health Insurance Company: _____

Policy/ID #_____ Social Security # of Policy Holder_____

Subscriber of Health Insurance: _____DOB:_____

Main Areas of Concern: _____

_____

Who referred you for Occupational Therapy Services: _____

936 Silas Deane Highway 3rd flr, Wethersfield, CT 06109, 860-721-9999
www.advancedtherapysolutionsct.com

Primary Diagnosis: _____ Secondary Diagnosis: _____

Primary Care Physician: _____

DEVELOPMENTAL AND MEDICAL HISTORY

Please check any of the following with whom you have received treatment. Please provide name and address:

[ ] Psychologist

Name and Address: _____

[ ] Neurologist

Name and Address: _____

[ ] Physical Therapist

Name and Address: _____

[ ] Speech Therapist

Name and Address: _____

[ ] Psychiatrist

Name and Address: _____

Please add additional comments or concerns:

_____

_____

936 Silas Deane Highway 3rd flr, Wethersfield, CT 06109, 860-721-9999
www.advancedtherapysolutionsct.com