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

HANDS ON THERAPY

P. O. Box 87 Norfolk, MA 02056
P: 508-560-4007 ◊ F: 508-520-4895
Jean@Hands-On-Therapy.com

INTAKE FORM

DATE _____

Personal Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone: Home: (___) _____ Mobile: (___) _____ Work: (___) _____

Email: _____

Occupation _____ Employer _____

Medical Information

Height _____ Weight _____

Medical diagnoses _____

Physician _____ Phone _____ Fax _____

Address _____

Insurance Information

Primary insurance carrier _____ ID# _____

Subscriber _____ Subscriber Date of Birth _____

Secondary insurance carrier _____ ID# _____

Subscriber _____ Subscriber Date of Birth _____

ASSIGNMENT OF BENEFITS. *I hereby assign all rights I have or may have for payment of services provided by the Provider named below under all of my health insurance policies, plans, and contracts, including without limitation those issued by Medicare and Blue Cross Blue Shield of Massachusetts, to the Provider named below and further, authorize and direct that all benefits that are or may be due thereunder be paid directly to:* Provider: Jean A. Croll NPI Number:1720219892

Date: _____ Client/Subscriber: _____

Print Name: _____

Do you have any of the following medical conditions?

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

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

SYMPTOMS

What is your primary complaint that brings you to treatment?

Secondary complaint?

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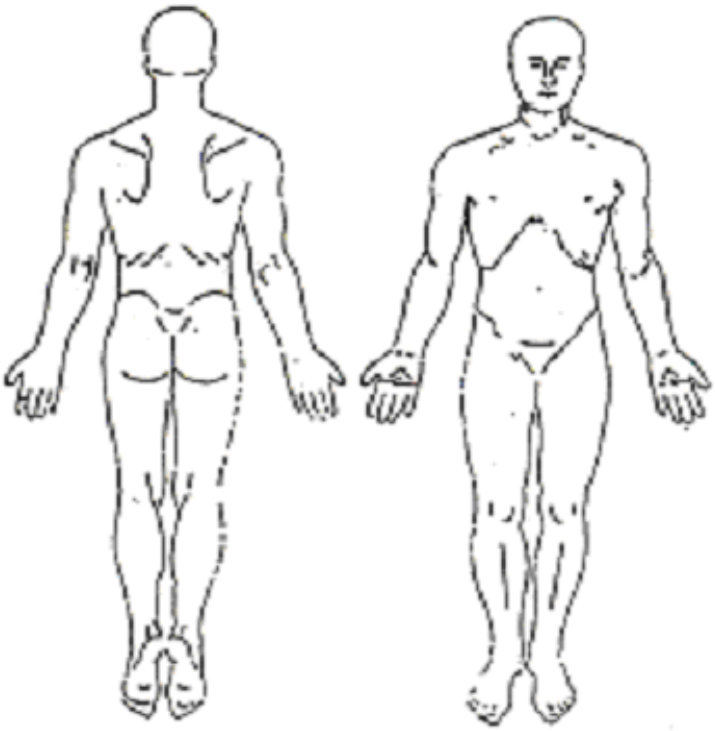
MEDICAL HISTORY *List past medical history/dates of occurrence. Include surgeries, accidents and other traumas. Use a separate sheet if necessary.*

MEDICATIONS *Please list all medications which you are currently taking. Include ALL prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. Use a separate sheet if necessary.*

Medication	*for treatment of*	*dosage*	*effectiveness*

Indicate areas of pain.
Note any scars.



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THERAPY GOALS *What are your goals for therapy? What can't you do now that you would like to do?*

1.

2.

3.

4.

I, _____, acknowledge that I have received and understand the NOTICE OF PRIVACY PRACTICES from Jean A. Croll, OTR/L d/b/a Hands On Therapy at 165 Main Street Medway MA 02053 or 17 Cocasset Street Foxboro MA 02035.

Signature_____Date_____

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 questions 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.

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_____

RELEASE OF INFORMATION: I hereby authorize Jean A. Croll, OTR/L to release my private health information, as may be necessary or required, to Medicare, health insurers, and those persons I have designated below. The authority granted may be revoked at any time by contacting Jean A. Croll at 508-560-4007.

NAME: _____ RELATIONSHIP: _____

ADDRESS:_____

PHONE: _____ FAX: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS:_____

PHONE: _____ FAX: _____

Signature_____ Date_____

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