



SAMUEL MERRITT  
UNIVERSITY

**Occupational Therapy Adult Clinic  
Client Fact Sheet**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address:  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Person to contact in case of emergency: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Primary Physician: Name: \_\_\_\_\_

Office Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

Referred by: \_\_\_\_\_

Presenting Problem:

Any Known Precautions (safety, balance, medication reaction, etc.):

Other Medical History (use the back if needed):

Current Medications:

Testing or Treatment Done Previously, or in Progress (where, when, and what kind of therapy and/or testing):

- A. Medical:
- B. Psychological:
- C. School:
- D. Other:

Please provide other pertinent information that you may wish to share with us:

Desired Clinic Time: (please mark one)

1:30 to 2:15 PM \_\_\_\_\_ 2:30 to 3:15PM \_\_\_\_\_ 3:30 to 4:15 PM \_\_\_\_\_

I \_\_\_\_\_ hereby give the occupational therapy  
(your name)  
department adult clinic at Samuel Merritt University permission to contact my  
physician for my medical record.

Client Signature: \_\_\_\_\_