Kristan Mosley's Therapy Farm
People and Animals Working Together
Kristan Trettel Mosley OTR/L
412-523-1316
kristankay@hotmail.com

PATIENT'S MEDICAL HISTORY AND PHYSICIAN' S STATEMENT

Name: _____ Date of Birth:_____
Height:_____ Weight:_____
Address:_____

Diagnosis:_____
Date Of Onset:_____
Surgeries:_____
Medications:_____
Seizure Type:_____ Date of last seizure:_____
Shunt present: Yes No
Special Precautions/Needs: _____
Mobility: _____
Braces/Assistive Devices: _____

Please indicate current or past difficulties in the following systems/areas:

			COMMENTS
Auditory	yes	no	
Visual	yes	no	
Tactile	yes	no	
Speech	yes	no	
Cardiac	yes	no	
Circulatory	yes	no	
Skin	yes	no	
Immunity	yes	no	
Pulmonary	yes	no	
Neurologic	yes	no	
Muscular	yes	no	
Balance	yes	no	
Orthopedic	yes	no	
Allergies	yes	no	
Cognitive	yes	no	
Emotional	yes	no	
Pain	yes	no	
Other	yes	no	

To my knowledge there is no reason why this person cannot participate in outpatient occupational therapy. However, I understand that Kristan Mosley's Therapy Farm, LLC will weigh the medical information above against the existing precautions and contraindications.

Signature _____Date_____Fax_____