RESILIENCE OT, LLC
functional interventions for a meaningful life
montpeliersi.com

Portals Center for Healing
28 School Street
Montpelier, VT 05602

IRVIN EISENBERG
OTR/L, BCSI, CPMT

irvin.eisenberg@gmail.com
w 607.237.5240
fax 802.821.4176

Name _____

Phone H _____ C _____ W _____

Mailing Address _____

Email _____

Permission to contact you by phone Y / N by mail Y / N by email Y / N

Date of Birth _____/_____/_____ Height _____ Weight _____

Referring MD _____ Primary MD _____

Reason for visit _____

Significant medical diagnoses and conditions

Y / N	Cancer - Type:	Y / N	Digestive problems / colitis / diarrhea
Y / N	Diabetes	Y / N	Kidney / bladder problems
Y / N	High Blood Pressure	Y / N	Hearing / ear problems
Y / N	Heart Disease	Y / N	Eye problems / glaucoma / detached retina
Y / N	Circulation problems / blood clots	Y / N	Depression / mental health problems
Y / N	Arthritis osteo / rheumatoid / other	Y / N	Are you / could you be pregnant?
Y / N	Osteoporosis / Ostopenia	Y / N	Other:
Y / N	Asthma / breathing problems	Y / N	Other:

Allergies (please list) _____

_____

Medication / Vitamins / Supplements	Dose	Frequency

Please list all significant surgical / invasive procedures Date

Please describe your current complaint or limitation _____

_____

When did your problem begin? _____ days ago _____ months ago _____ years ago

What makes your symptoms worse? _____

What makes your symptoms better? _____

Occupation _____

Do you participate in any sports or recreational activities (ie: walking, swimming, yoga)? Y / N

Please describe type and how often _____

Since the onset of symptoms, what has been the worst level of symptoms you have experienced?

0 1 2 3 4 5 6 7 8 9 10

no symptoms unbearable symptoms

What level are your symptoms right now?

0 1 2 3 4 5 6 7 8 9 10

no symptoms unbearable symptoms

Please describe the nature of your symptoms

☐ Sharp Pain
☐ Dull ache
☐ Burning
☐ Throbbing
☐ Numbness
☐ Tingling
☐ Shooting
☐ Other: _____
☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (25% or less)

What is your goal for therapy? _____

_____

Cancellation Policy

48 hours notice is required for all cancellations. There will be an $80 fee for cancellations not made prior to this time. The cancellation fee will be waived only if the scheduled slot is able to be filled.

I understand and agree to this Cancellation Policy.

Name _____ Signature _____

Date _____