**YOUR STORY – PLEASE SEND THIS PAGE BACK TO US**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_\_\_\_\_

Who completed this information? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide us with information that will help us know you and your family.

We appreciate this information as it helps us be better therapists for you. You can provide as much or as little information as you like. Remember: this form is used for all ages and abilities, so the questions may or may not be relevant. If you have already told me on the phone, you don’t need to repeat it here, I have it. Please answer as you feel comfortable.

What have you done in the past that was important to you?

How do you like to spend your time?

Who are the people and routines that help you the most through hard times?

Who else would you like us to work with from your support network?

Who are you worried about within your support network and why?

How will you know if we are helping you?

What do you know about your condition?

What are your fears and what are your goals?

What do you see yourself doing to assist in getting those goals met?

*Here’s to improved health!*

*Julie Groves and the Therapy In Your Home Therapists*