Physical Therapy through Healing Hands

______________Patient Questionnaire______________

Patient Name: ____

1. I am currently: ☐ employed ☐ not employed
   Occupation: ____________________________
2. Interests/ Hobbies are: ____
3. Next scheduled doctor appointment date: ____________ Doctor's name: ______________________

4. Medical conditions you have or have had. (*Check all that apply*)

____Arthritis	____Stroke	____Pacemaker
____Cancer	____Stomach Disorders *(ulcers, etc.)*	____Visual Problems
____Diabetes	____Anxiety	____Hearing Problems
____Heart Disease	____Depression	____Significant Weight Loss
____High Blood Pressure	____Panic Attacks	____Other ______________________
____Lung Disease	____Gland Problems (*thyroid)*	______________________
		______________________

5. Loss of bladder control? ____Yes or ____No
6. Loss of bowel control? ____ Yes or ____No
7. Is there any chance you might be pregnant? ____Yes or ____No
8. Do you smoke? ____Yes or ____No
9. Are you on a special diet? ____Yes or ____No Specify: ______________________________
10. Are you taking any medications? Yes or ____No If yes, please list: ______________________

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11. Do you have any allergies (*e.g. Adhesives, latex cortisone, rubbing alcohol, beeswax)*? ____Yes or ____No
    If yes, please list with any reactions/treatments *(please do not list medication allergies):*

________________________ *Reaction/Treatment*________________________

________________________*Reaction/Treatment*________________________

________________________*Reaction/Treatment*________________________

12. What do you want to achieve from having therapy?

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13. Please include any additional information you feel would help us provide your care *(i.e. what you think would help, any apprehensions about treatment, spiritual or cultural needs)*

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To the best of my knowledge, the above information is complete and factual.

____ ______________________

Patient Signature Date

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