HEALING HANDS THERAPY CENTER, LLC

111 Main Street, Collinsville, CT 06019

Phone: 860-404-2587 Fax: 860-404-5476

Patient Name _____Today's Date _____

Address _____City _____ State ___ Zip ____

DOB _____ Age _____ Gender _____ Marital Status _____

Do you smoke? If yes how much _____ Consume Alcohol? _____

Cell Phone _____ Home Phone _____

Email _____

Occupation _____

Recreational/Leisure Activities _____

Emergency Information/Nearest Relative

Name _____ Relationship _____

Cell Phone _____ Home Phone _____ Work Phone _____

How did you hear about us? _____

PATIENT QUESTIONNAIRE

Referring Physician _____

Past Medical History (please check all that apply)

___ High Blood Pressure ___ Diabetes ___Pacemaker

___ Seizures ___ Cancer ___ Autoimmune disorder

___ Other _____

_____

Allergies _____

Prior surgeries/injuries and dates _____

_____

Please list all Medications: _____

_____

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How and when did you current symptoms/injury occur? _____
_____
Have you had surgery for this condition? If so, when? _____

How is your current condition limiting you from doing what you need, want or love? _____
_____
_____
_____

List any tests that have been performed and results (ex: X-rays, MRI, CT scan, labs) _____
_____
Have you had any other treatments for your condition, please describe: _____
_____
Please rate your pain on a scale from 0 to 10 with 10 being the worst:
Pain at rest _____ Current level _____ Pain at worst _____
What makes your pain/symptoms better or worse? _____
_____
Please tell me where your symptoms are in your body:_____
_____
_____
_____
_____

Have you ever had this condition in the past? _____ If yes, when? _____
What are your goals/expectations for therapy? _____
Is there anything else you would like us to know? _____
_____
_____

Signature _____ Date _____
Printed Name _____