Healing Hands Therapy
Intake Questionnaire

File #_____

Name:		Date:	
Height	Weight:	DOB:	Age:

What are you seeking treatment for? _____

When did your present symptoms start? _____

What do you think caused your symptoms? _____

Are your symptoms currently: ☐ Getting Better ☐ Getting Worse ☐ Staying about the same

My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

Have you ever had this problem before? Yes No If yes, when? _____

What treatments have you tried so far? (chiropractic, injections, etc) _____

Special tests formed / scheduled for this problem (MRI, x-ray, labs) _____

Name of referring physician (if no referral, primary care physician) _____

Have you seen a physical therapist already this calendar year? How many visits? _____

Are you on work restriction from your doctor? Yes No Are you pregnant? Yes No

Do you smoke? Yes No Do you drink alcoholic beverages? Yes No

What is the severety of your pain?

	No Pain										Worst Pain Imaginable
At its *worst*:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10
At its *best*:	0	1	2	3	4	5	6	7	8	9	10

What is your ovreall average level of function?

Cannot do anything										Able to do everything
0	1	2	3	4	5	6	7	8	9	10

When are your symptoms the worst?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

When are they the best?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

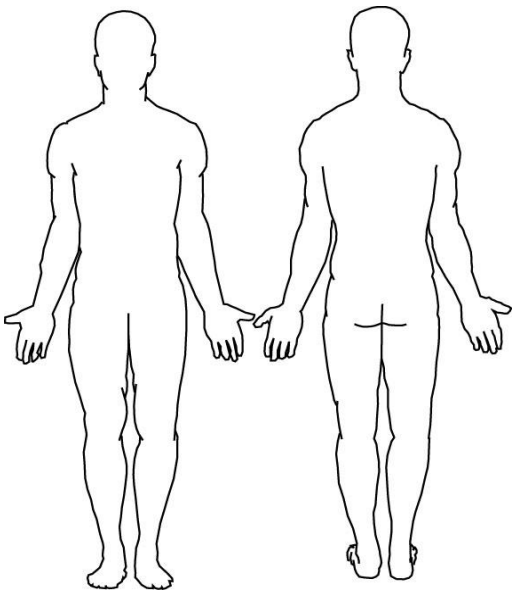
Have you RECENTLY noted any of the following?

- ☐ Pain/Tenderness
- ☐ Headaches
- ☐ Fatigue
- ☐ Muscle weakness
- ☐ Loss of balance
- ☐ Nausea/Vomiting
- ☐ Shortness of breath
- ☐ Difficulty sleeping
- ☐ Fever/Chills/Sweats
- ☐ Sudden weight loss
- ☐ Dizziness / Lightheadedness
- ☐ Heartburn/Indigestion
- ☐ Difficulty swallowing
- ☐ Vision problems
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Incontinence
- ☐ Discolored urine
- ☐ Difficulty starting flow
- ☐ Frequency/urgency

Please mark the areas you feel symptoms
Use the symbols to describe them:

↓ Shooting/sharp pain O Dull/aching pain

Numbness ∴ Tingling



Front Back

Aggravating Factors: (Positions or Activities)

1 _____

2 _____

3 _____

Easing Factors: (Positions or Activities)

1 _____

2 _____

3 _____

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Have you EVER been diagnosed with the following?

- ☐ Cancer
- ☐ Asthma
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Depression
- ☐ Tuberculosis
- ☐ Lung problems
- ☐ Heart problems
- ☐ Liver problems
- ☐ Infertility
- ☐ Endometriosis
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Multiple sclerosis
- ☐ Thyroid problems
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease/HIV
- ☐ Pelvic inflammatory disease
- ☐ Chest pain/heart palpitations
- ☐ Chemical dependency (alcoholism)
- ☐ Bone or joint infection
- ☐ Eye problem/infection
- ☐ Fibromyalgia

Has anyone in your immediate family EVER been diagnosed with any of the following?

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Stroke
- ☐ Psychological
- ☐ Tuberculosis
- ☐ Abdominal Aortic Aneurysm
- ☐ Thyroid problems
- ☐ Blood clots
- ☐ Arthritis

In the past 2 weeks, have you felt down, depressed or hopeless? Yes No
Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes No
If you checked Yes, are you currently under the care of a counselor or psychiatrist? Yes No
Is this something with which you would like help? Yes Yes, but not today No

Fall History:

Have you sustained an injury as a result of a fall in the past year? Yes No
Have there been two or more falls in the last year? Yes No

Medications you are currently taking:

Name of Medication	Dosage	Frequency	Date prescribed	Why you are taking?

Have you ever taken steroid medications? Yes No
Have you ever taken blood thinning or anticoagulant medications? Yes No

Please list any surgeries:

Body Region (I.g. Right leg, back)	Surgery Procedure	Date	Any post surgery complications?

Patient Signature: _____ Date: _____

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