HAND TO HAND THERAPY CLINIC, LLC

PATIENT HEALTH QUESTIONNAIRE

NAME*(LAST,FIRST):*	**DATE:**

PERSONAL HEALTH HISTORY **List any medical problems that other doctors have diagnosed or surgeries that you have had:**

Allergies to medications: Yes No	
Name of medicine:	Reaction you had:

Are you allergic to:

Latex: Yes No

Iodine: Yes No

Any other allergies? Please list:

List your prescribed drugs and over the counter drugs including vitamins:		
Name of Drug	**Strength**	**Frequency Taken**

HEALTH HABITS		
Alcohol	Tobacco	Caffeine

PAIN SCALE									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

	OTHER CONDITIONS:	**Please circle any that apply:**
Diabetes	Pacemaker	Any Blood Disorder
Cancer	High Blood Pressure	Tuberculosis
Bone/Joint Problems	Hepatitis	Osteoporosis
Epilepsy/ Seizures	HIV Positive/AIDS	Pregnancy
Arthritis-Rheumatism	Heart Related Problems	Changes in sleep/energy/wght
Neurological Problems	Stroke	Asthma
Briefly explain:		

Please list any healthcare professionals who are following your care for this condition(MD's, therapists, case managers)**:**	
Name:	Phone #:
Name:	Phone #:

Name:	Phone #: