The Hetrick Center
You Have A Choice For Your Physical Therapy...Choose Us!

PATIENT HISTORY QUESTIONNAIRE

Date:_____ Whom may we thank for referring you? _____

Name: _____ **DOB:** _____ **Age:** _____ **SSN:** _____

Blood Pressure: _____ **(Circle) R or L handed** **Height:** _____ **Weight:** _____

Home Telephone: _____ **Cell Phone:** _____ **Home Email:** _____

Family Doctor: _____ **Phone Number:** _____

Emergency Contact Person: _____ **Phone Number:** _____

Race: (circle one)

White Asian Japanese Samoan Black/African American Asian Indian Korean Filipino Guamanian Hispanic Chinese Vietnamese American Indian/Alaskan Native Native Hawaiian or other Pacific Island Multiracial Other _____

I choose not to specify

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (circle one)

English Spanish American Sign Language Chinese French German Tagalog Greek Italian Vietnamese Korean Russian Polish Arabic Portuguese Japanese French Creole Hindi Urdu Persian Gujarati Armenian I choose not to specify

Verification Question (choose only one by circling the question, then give the answer to that question)

What is the name of your favorite pet? In what city were you born? What is your favorite movie? When is your anniversary?

What is your mother's maiden name? On what street did you grow up? What high school did you attend? What was the make of your first car?

Verification Answer to the Chosen question: _____ **(MUST BE 6 CHARACTERS LONG)**

Do you currently smoke tobacco of any kind? Yes Former Smoker Never been a smoker

If yes, how often do you smoke: Current everyday smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking? (0= No interest, 10= Very interested)

0 1 2 3 4 5 6 7 8 9 10

Has any doctor presently diagnosed you with Hypertension? Yes No If yes, describe: _____

_____ **Onset date:** _____

Has any doctor presently diagnosed you with Diabetes? Yes No If yes, what kind? Type I Type II

If yes, was your blood test for Hemoglobin A1c >9.0%? Yes No Not sure

If yes, other comments regarding your Diabetes _____

_____ **Onset Date** _____

Current Medications, including frequency and dosage, if known. (Or provide our office with a copy of your list) Check here if no medications ☐

Medication Name:	Dosage:	Frequency	How Taken:

List any known allergies you have had to any medications. Check here if no allergies ☐

_____

_____

Please list all current medical issues and when they began:

1. _____ **2.** _____

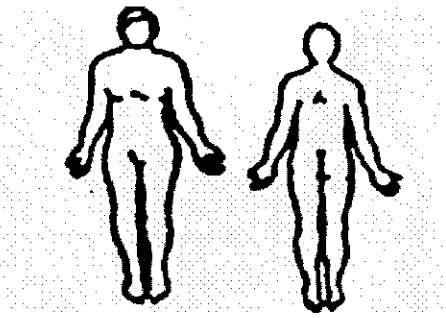
3. _____ **4.** _____

What are the current complaints that bring you into the office today and when did they begin? _____

_____

To help us better understand the nature and origin of your complaints, we ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts on the figures.

//////////////	Dull Ache/Throb
XXXXXX	Sharp/Stabbing
BBBBBB	Burning
OOOOOO	Numbness
::::::::::::::	Tingling
CCCCCC	Cramping



Have you ever had X-rays? Y N If yes: Date:_____ **For what:** _____

Have you ever had MRI's? Y N If yes: Date _____ **For what:** _____

Have you had an X-ray, CT scan, or MRI of your <u>LOW BACK</u> spine in the past 28 days? Y N

Other Clinical Tests: Have you ever had any of the following tests? (Circle all that apply):

Angiogram Blood Tests Doppler Ultrasound Mammogram Urine/Stool tests Bone Scan Biopsy Echocardiogram

Myelogram Arthroscopy Stress Tests (treadmill/bicycle) CT Scan NCV/EMG EEG/EKG Other: _____

Thank you for completing this form. The information you have provided will assist us in attending to your healthcare needs.

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a rehabilitation exercise program or care designed for me if determined to be clinically medically necessary by my doctor or therapist. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor, therapist or assistant of any possible complication prior to the initiation of my daily rehabilitation or treatment.

Your signature _____ Date_____

Provider signature _____ Date _____