The Hetrick Center

Patient History Questionnaire

Date:_______________ Referred By: ________________________

Name: ____ DOB: ____________ Age: _____ SSN: _______________

Home Telephone: _______________ Cell Phone: _______________ E-mail: ___________________________

Blood Pressure: _______ Weight: _______ Height: _______ (Circle) R or L Handed (Check) ☐Medication List Attached

Emergency Contact Person: __________________ Phone: _________________ Family Doctor: ____________________

History of Current Condition

What is your complaint? ____

____

(Check all that apply)

1. What type of pain is it? ☐Sharp/Stabbing ☐Ache ☐Dull ☐Burning ☐Throbbing ☐Numbness ☐Tingling ☐Cramping

2. Rate pain on a scale of 0 - 10
(Please Circle) (0 = no pain 10 = severe pain)

Currently	0 1 2 3 4 5 6 7 8 9 10
Average	0 1 2 3 4 5 6 7 8 9 10
At Best	0 1 2 3 4 5 6 7 8 9 10
At Worst	0 1 2 3 4 5 6 7 8 9 10

3. How long have you had this pain?

____

4. What makes the pain worse? ______________________

____

5. What makes the pain better? ______________________

____

6. Does the pain travel? _____ If so, where

____

7. Is pain worse at any particular time of day?

____

8. Date of onset _____/_____/_____

9. Is the pain getting better or worse?_________________

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
X	Sharp/Stabbing
B	Burning
O	Numbness
::	Tingling
C	Cramping

Additional Comments:

____

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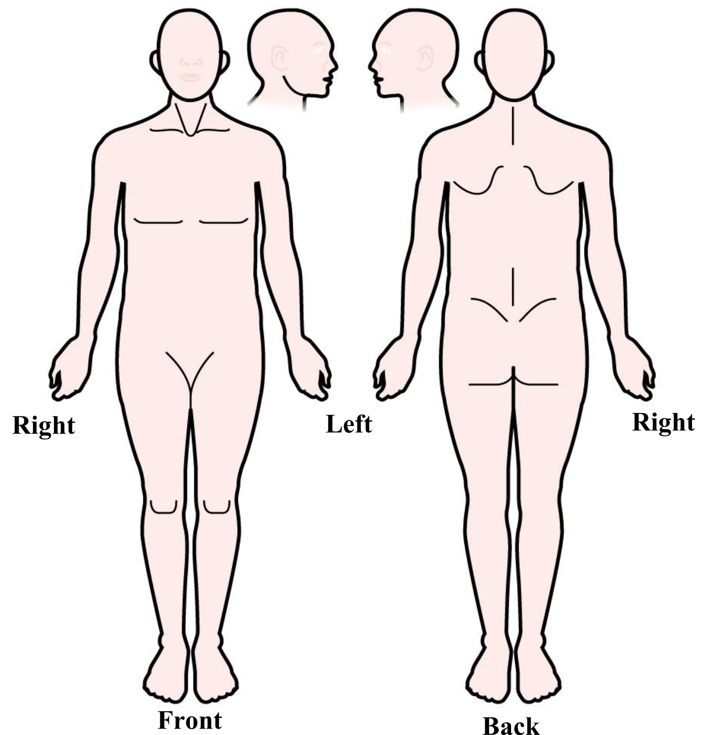

Please list all current and past medical conditions, please note if they are under current medical treatment.

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

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: ______________________

Other Clinical Tests: Have you had any of the following tests? Check all that apply

☐Angiogram ☐Blood tests ☐Doppler Ultrasound ☐Mammogram ☐Urine/Stool Tests
☐Bone Scan ☐Biopsy ☐Echocardiogram ☐Myelogram ☐Stress Tests
☐Arthroscopy ☐CT Scan ☐EEG/EKG/EMG ☐NCV/EMG ☐Other:__________

Is your current condition related to a work injury or an automobile accident? Y N If yes, which one? ______________
Have you ever sustained a work injury for which you received treatment? Y N If yes, when? ______________

Describe your Home/Work/Recreational Activities and any difficulties that you have with these activities: ______________

____

With Whom do you live: ______________ Do you use an assistive device: Y N Type of device: ______________
Does your home have: ☐Stairs, no railing ☐Stairs, railing ☐Wheelchair ☐Ramps ☐Uneven Terrain ☐Elevator

☐Obstacles: ______________ ☐Assistive Devices (e.g. bathroom):______________

General Health Questions

Do you use tobacco products? Y N If yes, indicate what kind, how much you use (i.e. packs/day,) and for how long that you have used the products. ______________

Have you ever used tobacco products? Y N If yes, how long have you do so, when did you quit? ______________

Do you drink alcohol? Y N If yes, how much/what type do you consume per week ______________

Is your history significant for recreational drug use? Y N Describe ______________

My diet is: ☐balanced ☐not balanced. Recent weight change: ☐Gained ☐Lost How much? ______________

My rest is: ☐sufficient ☐insufficient. Hours of sleep/ night ________

I exercise: ☐0x/week ☐1-2x/week ☐3-4x/week ☐5x/week or more

My recreation is: ☐sufficient ☐insufficient

My family stress is: ☐severe ☐moderate ☐minimal ☐none

Occupation: ______________________

How do you like your work? ☐above average ☐average ☐below average ☐N/A

My job stress is: ☐severe ☐moderate ☐minimal ☐none ☐N/A.

I have experienced: ☐nervousness ☐irritability ☐fatigue ☐depression ☐run down feeling
☐craving for sweets ☐craving for salts

Please check the following conditions that you have or have had:

☐AIDS ☐Anemia ☐Arthritis ☐Cancer ☐Diabetes ☐Epilepsy ☐Hardening of the arteries ☐Heart attack ☐Hepatitis C

☐High blood pressure ☐HIV ☐Low blood sugar ☐Multiple sclerosis ☐Parkinson's Disease ☐Polio ☐Rheumatic fever

☐Stroke ☐Tuberculosis ☐Venereal Disease

Please check the box if you have any of the following symptoms:

Head ☐N/A

☐Unusually frequent headaches (R or L) ☐Unusually severe headaches ☐Head feels heavy ☐Vertigo

☐Facial numbness (R or L) ☐Light-headedness ☐Loss of smell ☐Loss of taste ☐Loss of balance ☐Previous head trauma

Neck ☐N/A

☐Neck pain with movement (R or L) ☐Swelling in neck ☐Stiff neck ☐Pinched nerve in neck (R or L)

☐Dizziness with neck movement ☐Neck feels out of place ☐Muscle spasms in neck ☐Abnormal sounds in neck

☐Previous neck injury

Shoulders ☐N/A

☐Pain in shoulder (R or L) ☐Pain across shoulders ☐Tension in shoulders ☐Muscle spasms in shoulders

☐Can't raise arm above shoulder level ☐Can't raise arm over head ☐Previous shoulder injury

Arms & Hands ☐N/A

☐Pain in upper arm (R or L) ☐Pain in forearm (R or L) ☐Pain in hands (R or L) ☐Pain in fingers (R or L)

☐Fingers go to sleep ☐Sensation of pins and needles in arms ☐Sensation of pins and needles in fingers ☐Cold hands

☐Swollen finger joints ☐Sore finger joints ☐Loss of grip strength ☐Previous injury to hand

Mid back ☐N/A

☐Pain between shoulder blades (R or L) ☐Mid back pain (R or L) ☐Pain from front to back ☐Pain over kidney area (R or L)

☐Muscle spasms in mid back ☐Pain below shoulder blades with exercise ☐Previous mid-back injury

Low back ☐N/A

☐Low back pain (R or L) ☐Low back feels out of place ☐Muscle spasms in low back ☐Previous low-back injury

Hips, Legs, & Feet ☐N/A

☐Pain in buttocks (R or L) ☐Pain down leg (R or L) ☐Knee pain (R or L) ☐Leg cramps ☐Sensation of pins and needles

☐Numbness in legs ☐Numbness in toes ☐Cold feet ☐Swollen ankles ☐Swollen feet ☐Previous hip/leg/foot injury

Cardiovascular ☐N/A

☐General swelling ☐Swelling in legs ☐Swelling in face ☐Swelling around eyes ☐Chest pain ☐Heart "jumps"

☐Pounding heartbeat ☐Rapid heartbeat ☐Irregular heartbeat ☐Blue or purple skin ☐Fainting ☐High blood pressure

☐Poor circulation ☐Heart murmurs ☐Difficulty laying flat ☐Chest pain with exercise

Hair, Skin, & Nails ☐N/A

☐Baldness ☐Dry scalp ☐Oily scalp ☐Eczema ☐Psoriasis ☐Itchy skin ☐Rough, scaly scalp ☐Dry skin ☐Oily skin

☐Yellow skin ☐Bruise easily ☐Pale skin ☐Rashes ☐Skin cancer ☐Sensitive skin ☐Paper thin nails ☐Nail biting

☐Allergies to Chlorine/Bromine

Eyes ☐N/A

☐Blurred vision ☐Double vision ☐Eyes fatigue easily ☐Excessive tearing ☐Lack of tearing ☐Light bothers eyes

☐Excessive itching ☐Pain in the eye(s) ☐Periods of blindness in eye(s) ☐Red eyes ☐Night blindness ☐Pain behind eyes

Please check the box if you have any of the following symptoms:

Ears ☐N/A

☐Hearing loss (R or L) ☐Pain in ears ☐Discharge from ears ☐Vertigo ☐Ringing in ears

Nose/Nasopharynx/Sinuses ☐N/A

☐Unusual nasal discharge ☐Nose bleeds ☐Pressure over eyes ☐Pressure under ☐Frequent colds ☐Obstruction of nose

☐Sinusitis ☐Nasal allergies ☐Loss of sense of smell ☐Any trauma to nose

Mouth & Throat ☐N/A

☐Pain in mouth ☐Pain in throat ☐Bleeding gums ☐Cavities ☐Abscessed teeth ☐Dentures ☐Difficulty swallowing

☐Changes in voice

Respiratory ☐N/A

☐Shortness of breath ☐Asthma ☐Chronic cough ☐Difficulty breathing while lying down ☐Dry cough ☐Wheezing

☐Difficulty sleeping while lying down ☐Productive cough ☐Coughing up blood ☐Abnormal chest x-ray

Gastrointestinal ☐N/A

☐Poor appetite ☐Constant nibbling ☐Indigestion ☐Stomach upsets from food ☐Stomach upsets from liquid ☐Ulcers

☐Stomach upsets from medicines ☐Abdominal pains ☐Stomach gas before meals ☐Stomach gas with meals ☐Diarrhea

☐Stomach gas after meals ☐Change in bowel habits ☐Constipation ☐Hemorrhoids ☐Loss of bowel control ☐Jaundice

☐Liver disease ☐Hepatitis ☐Gall bladder disease ☐Abdominal bloating # of bowl movements/day ___________

Genitourinary ☐N/A

Urination is: Frequent / Infrequent? Amount is: High / Low? ☐Need to get up at night to urinate ☐Painful urination

☐Difficult to start/stop urination ☐Dribbling ☐Incontinence ☐Blood in urine ☐Cloudy urine ☐Lack of bladder control

☐Back pain with urination ☐Stream flow abnormality

Female Only

☐Painful periods ☐Missed menstrual periods ☐Irregular cycles ☐Spotting ☐Vaginal discharge ☐Lumps in breasts

☐Wear an IUD ___# of pregnancies ___# of deliveries ___# of vaginal deliveries ___# of C-sections ___# of complicated -deliveries ☐LBP w/ menses ☐LBP w/ pregnancy ☐Fibroid tumors ☐Ovarian cysts ☐Nipple discharge

☐Tubal pregnancy ☐Excessive menstrual flow ☐Premenstrual symptoms Date of last menstrual period ____________

Male Only

☐Impotence ☐Testicular swelling/pain ☐Testicular masses ☐Blood in sperm ☐Prostate disease ☐Premature ejaculation

Cancer

Do you have a history of cancer? Y N If yes, please describe:

____

____

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 ________________

Current Medications/Supplements

The Hetrick Center

Date Completed: ____/____/____

☐ Please check if you have attached your own list.

Medication or Supplement name:	**Dosage:**	**Frequency:**	**Date you started:**
1.			
2.			
3.			
4.			
5.			
6			
7			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

List any known allergies you have had to any medications:

____

____

____

____

____

Please keep us updated of any changes in medications or supplements that you are taking by reprinting and submitting this form.