Patient History Questionnaire Update

The Hetrick Center

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?

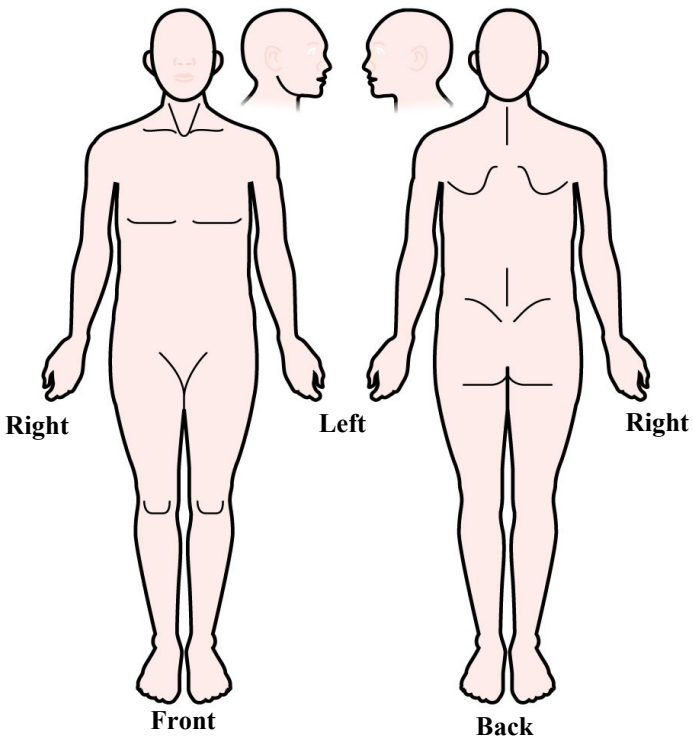
_____

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



Additional Comments:

_____

_____

_____

_____

_____

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? _____

Surgeries, medical procedures, and/or hospilizations (list and date):_____

_____

When was the last time you presented to your family physician? _____

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 overall stress is: ☐severe ☐moderate ☐minimal ☐none

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

Patient Name: _____ 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.