



The Hetrick Center
"Your Multidisciplinary Solution"

PATIENT HISTORY QUESTIONNAIRE

Date: _____ Referred by: _____

Name: _____ DOB: _____ Age: _____

S.S.N.: _____ Weight: _____ Height: _____ Tel #: _____

Emergency Contact Person: _____ Tel#: _____

Do you have Advance Directives or a delineated power of attorney for your medical care? Y N (If yes, please provide us with a copy)

List, in order of importance, your Primary Medical Issues that bring you to The Hetrick Center:

1. _____
2. _____
3. _____
4. _____

List, in order of importance, other Medical Issues you may be seeing other providers for: (List issue & provider)

1. _____
2. _____
3. _____

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 ever had other tests/studies? Y N If yes list below:

1. Date: _____ Study/Test: _____ Treatment received: _____
2. Date: _____ Study/Test: _____ Treatment received: _____
3. Date: _____ Study/Test: _____ Treatment received: _____

Have you seen any other providers for your presenting complaint(s) today? Y N If yes, list their name and specialty: _____

What types of treatment(s) have you received, if any, for your presenting condition(s)? _____

What medications and dosages are you currently taking?

Please mark with an "x" the following that you have taken in the past 2 months: ___vitamins ___herbs

___laxatives

___stomach/GI/reflux medicine ___birth control pills ___beta blockers ___muscle relaxers ___pain medicine

___cold/cough medicine ___hormone replacements ___appetite curb pills ___thyroid medication ___insulin



Is your current condition related to a work injury or an automobile accident? Y N If yes, which one? _____

Have you ever been in an automobile accident? ___past year ___past 5 years ___over 5 years ago ___never

Have you ever sustained a work injury for which you received treatment? Y N If yes, when? _____

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

___AIDS ___Anemia ___Arthritis ___Cancer ___Diabetes ___Epilepsy ___Hardening of the arteries
___Heart attack ___High blood pressure ___Low blood sugar ___Multiple sclerosis ___Parkinson's Disease
___Polio ___Rheumatic fever ___Stroke ___Tuberculosis ___Venereal Disease

Please mark if you have any of the following symptoms:

Head

___Unusually frequent headaches ___Unusually severe headaches ___Head feels heavy ___Vertigo ___ facial numbness

___Light-headedness ___Loss of smell ___Loss of taste ___Loss of balance ___Previous head trauma

Neck

___Neck pain with movement ___Swelling in neck ___Stiff neck ___Pinched nerve in neck ___dizziness with neck movement

___Neck feels out of place ___Muscle spasms in neck ___Abnormal sounds in neck ___Previous neck injury

Shoulders

___Pain in shoulder (right or left) ___Pain across shoulders ___Tension in shoulders

___Muscle spasms in shoulders ___Can't raise arm above shoulder level ___Can't raise arm over head

Arms & Hands

___Pain in upper arm ___Pain in forearm ___Pain in hands ___Pain in fingers ___Fingers go to sleep

___Sensation of pins and needles (___in arms ___in fingers) ___Cold hands ___Swollen finger joints

___Sore finger joints ___Loss of grip strength

Mid back

___Pain between shoulder blades ___Mid back pain ___Pain from front to back ___Pain over kidney area

___Muscle spasms in mid back ___ pain below shoulder blades with exercise

Low back

___Low back pain ___Low back feels out of place ___Muscle spasms in low back

Hips, Legs, & Feet

___Pain in buttocks ___Pain down leg ___Knee pain ___Leg cramps ___Sensation of pins and needles

___Numbness in legs ___Numbness in toes ___Cold feet ___Swollen ankles ___Swollen feet

Cardiovascular

___General swelling ___Swelling in legs ___Swelling in face ___Swelling around eyes ___Chest pain

___Pounding heartbeat ___Heart "jumps" ___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

___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

___Blurred vision ___Double vision ___Eyes fatigue easily ___Excessive tearing ___Lack of tearing

___Light bothers eyes ___Excessive itching ___Pain in eyeball (s) ___Periods of blindness in eye (s)

___Red eyes ___Night blindness ___Pain behind eyes

Ears

___Loss of hearing ___Pain in ears ___Discharge from ears ___Vertigo ___Ringing in ears

Nose/Nasopharynx/Sinuses

___Unusual nasal discharge ___Nose bleeds ___Pressure over eyes ___Pressure under eyes ___Frequent colds

___Obstruction of nose ___Sinusitis ___Nasal allergies ___Loss sense of smell ___Any trauma to nose

Mouth & Throat

___Pain in mouth ___Pain in throat ___Bleeding gums ___Cavities ___Abscessed teeth ___Dentures

___Difficulty swallowing ___Changes in voice



Respiratory

Shortness of breath Asthma Chronic cough Difficulty breathing while lying down Dry cough
 Difficulty sleeping while lying down Productive cough Coughing up blood Wheezing
 Abnormal chest x-ray

Gastrointestinal

Poor appetite Constant nibbling Indigestion Stomach upsets from food Stomach upsets from liquid
 Stomach upsets from medicines Abdominal pains Stomach gas before meals Stomach gas with meals
 Stomach gas after meals Change in bowel habits Diarrhea Constipation
 Hemorrhoids Ulcers Loss of bowel control Jaundice Liver disease Hepatitis Gall bladder disease
 Abdominal bloating

Genitourinary

Urination is: Frequent / Infrequent? Amount is: High / Low? Need to get up at night to urinate Difficult to start/stop urination
 Painful 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
 Premenstrual symptoms Lumps in breasts Wear an IUD # of pregnancies # of deliveries # of vaginal deliveries
 # of C-sections Complicated deliveries LBP w/ menses LBP w/ pregnancy
 Fibroid tumors Ovarian cysts Nipple discharges Tubal pregnancy Date of last menstrual period
 Excessive menstrual flow PMS symptoms

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 _____

General Health Questions

Do you use tobacco products? Y N If yes, indicate what kind, how much you use, and for how long you have used the products _____

If you do not curectly use tobacco, have you ever used the products? Y N If yes, describe what you used, how long did you use the product, and when you quit _____

Do you drink alcohol? Y N If yes, how much do you consume per week _____

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

My diet is balanced not balanced.

My rest is sufficient insufficient.

My recreation is sufficient insufficient.

My family stress is severe moderate minimal none.

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

Does your past history include any hospitalizations or surgeries? Y N If yes, please elaborate on when, where, what, etc. _____

Are you: Single Married Divorced Separated Widowed (circle one)



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Do you have any children? Y N If yes, please list their sex and their ages _____

Do your children have any major medical problems (past or present)? Y N If yes, please describe _____

Do you have any siblings? Y N If yes, please list any major medical problems that are part of your siblings' history _____

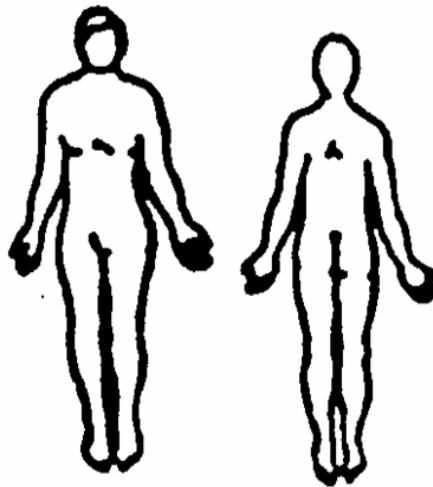
Are your parents still living? Y N Are there any major medical problems (past or present) that are part of your parents' history? Y N If yes, please describe _____

Do your maternal or paternal grandparents have any major medical problems (past or present) that are part of their history? Y N If yes, please describe _____

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 (10 being severe pain): ___ Average ___ Better ___ Worse ___ Over past week
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 ___/___/___ Date of same or similar symptoms ___/___/___

To help us better understand the nature & 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



Thank-you for completing this form. The information you have provided will assist us in attending to your health-care 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 _____

Physician signature _____ Date _____