THE HETRICK CENTER

You have a choice for Physical Therapy…choose us!

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Worker's Compensation History

Patient Name: ____

Date of Birth: ____/____/________ Date of Accident/Injury: ____/____/______

Instructions: Please complete this form to the best of your ability. Please fill-in your answers on the line or circle the appropriate answer.

1. Name of employer at time of accident: ______________________________
2. Length of time worked there prior to accident: ______________________________
3. Type of work being done at time of injury: ______________________________
   ____
4. In your own words, please describe accident:
   ____
   ____
   ____
5. Have you been treated by another doctor for this accident? Yes No
   If yes, please list Doctor's name and address: ______________________________
   ____
   What type of treatment did you receive? ______________________________
   How long were you treated by this Doctor? ______________________________
6. Are you: Improved Unchanged Don't know
7. What medications are you currently taking? (List name and dosage)
   ____
   ____
   Do these medications help? Yes No Don't know
8. Have you had Physical Therapy? Yes No
   If yes, how often? (circle one)
   Daily Every other day Several times a week Weekly
   Every other week Monthly Other: ____________
   Did Physical Therapy help? Yes No Don't know
9. Prior to this accident, have you ever had any physical complaints similar to what you have now? Yes No Don't know
   If yes, please describe. ______________________________
   ____
10. Were these similar complaints due to a previous accident(s)? Yes No
11. Have you had any other serious accidents which required medical care? Yes No
    If yes, please describe. ______________________________
    ____

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Have you had any serious illnesses that required hospitalization? Yes No
If yes, please describe. ____

____

12. Have you had any surgeries? Yes No
If yes, please list date and type. ____

____

13. Have you had any nervous or mental illness? Yes No
14. Have you had psychiatric care? Yes No
15. Have you received a medical discharge from the Armed Services? Yes No
16. Have you returned to work since this accident? Yes No
17. If you have returned to work, please fill out the information below.

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY or REGULAR DUTY	FULL TIME or PART TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: low back mid back upper back
2. My pain began: gradually suddenly
3. I have pain: sometimes all of the time
4. My pain goes into my: right leg left leg both
5. I have tingling and/or numbness in: right leg left leg both
6. My pain is worse when I: (Circle all that apply)
   Cough or Sneeze Walk Pull
   Sit Lift
   Bend Push
7. My back is worse with sexual activity. Yes No
8. My pain wakes me up during the night. Yes No
9. Changes in the weather affect my pain. Yes No

NECK PAIN:

1. My neck pain began: gradually suddenly
2. I have pain: sometimes all of the time
3. My pain goes into my: right arm left arm both
4. I have tingling and/or numbness in: right arm left arm both
5. My pain is worse when I: (Circle all that apply)
   Cough or Sneeze Push
   Bend Forward Pull
   Lift Turn my head

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6.	My pain wakes me up during the night.	Yes	No
7.	Changes in the weather affect my pain.	Yes	No
8.	I have neck stiffness.	Yes	No
9.	I have headaches.	Yes	No
	If I do get headaches, they occur:	Sometimes	All of the time

OTHER PAIN:
Please describe any current medical complaints which you are experiencing that have not been covered on the questionnaire or list any additional comments you wish to make regarding your condition.

____
____
____
____

JOB DESCRIPTION

In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34-66% and "continuously" means 67-100% of the workday.

1. In a typical 8 hour workday, I: (Circle # of hours per activity)

Sit:		1	2	3	4	5	6	7	8
Stand:	1	2	3	4	5	6	7	8	
Walk:	1	2	3	4	5	6	7	8	

2. On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	□	□	□	□
Squat	□	□	□	□
Crawl	□	□	□	□
Climb	□	□	□	□
Reach above Shoulder height	□	□	□	□
Crouch	□	□	□	□
Kneel	□	□	□	□
Balancing	□	□	□	□
Pushing/Pulling	□	□	□	□

3. On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	□	□	□	□
11-24 pounds	□	□	□	□
25-34 pounds	□	□	□	□
35-50 pounds	□	□	□	□
51-74 pounds	□	□	□	□
75-100 pounds	□	□	□	□

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4. Do you have to bend over while doing any lifting? Yes No
5. Are your feet used for repetitive movements, such as operating foot controls? Yes No
6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
Right hand:	Yes	No	Yes	No	Yes	No
Left hand:	Yes	No	Yes	No	Yes	No

7. Are you required to work on unprotected heights? Yes No
   If yes, please describe. ______________________________
   ____
8. Are you required to work around moving machinery? Yes No
   If yes, please describe. ______________________________
   ____
9. Are you exposed to marked changes in temperature and humidity? Yes No
   If yes, please describe. ______________________________
   ____
10. Are you required to drive automotive equipment? Yes No
   If yes, please describe. ______________________________
   ____
11. Are you exposed to dust, fumes or gas? Yes No
   If yes, please describe. ______________________________
   ____
12. Please list any additional comments you may have.
   ____
   ____
   ____

Patient Printed Name: ______________________________

Patient Signature: ______________________________ Date: ______________________________

Provider Signature: ______________________________ Date: ______________________________

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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

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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

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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 ________________